07-03214	
Robert Wilson	

obert Wilson	State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.
Physician/	Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death
ledical Examiner	Robert Martin Wilson April 27, 2007
*	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Franklin Square Hospital 4c. County of Death Rosedale Baltimore County
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or
Director	217-36-3057 1x M 2 F 67 Yrs. Months Days Hours Min. Aug. 6, 1939 Foreign Country) Maryland
	Usual Residence of Decedent
ow any.	1 Yes 2 X No
Maryland 28a-f show 1 at once	Maryland Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
the Maryland a or 28a-f sh tiffed at onc	327 Crestwood Court 21040 USA
death with the Maryland or items 23a or 28a-f sho must be notified at once-uneral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-
r death with or items 23 must be no Funeral	Never Married 2 X Married 1 V Yes 2 No
hours after 'natural'', Examiner ted by	at Dependent's Education (Specific only highest grade completed). 16a Dependent's Usual Occupation (Give kind of work done 16b, Kind of Business/Industry
5-0036 ed within 72 hour tygiene. other than "natt on Medical Exan Completed	Elementary/Secondary (0-12) College (1-4 or 5+) Guiring most of working life. DO NOT use retired)
5-0036 led within 72 Hygiene. other than th Medical	12 Driver Dairy
215-0036 be filed within 7 had Hygiene. eked other than ent, the Medica	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	William Ind Wilson Dev
MD nd 2 sho alth and m 27 is aumati	Mildred Wilson / Wife 327 Crestwood Court, Edgewood, Maryland 21040
s l and of Heal	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 1 Burial 2 XCremation 3 Removal from State crematory or other place) 20c. Location - City or Town, State
Baltimore, permit. Pages I an Department of Hee Important: If ite	4 Donation 5 Other Specify: Hilltop Service Corp. 4-30-07 Towson, Maryland
Balti permit. Departm Imports injury o	22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and
Medical aminer	Immediate Cause (Final disease a. Intertensive atherosclerotic cardiovascular disease
,	or condition resulting in death) Due to (or as a consequence of):
Jer Jer	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):
red Insit	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):
ecuted and ransit	d.
Box 68760, death certificate be executed the attending physician and offor use as the burial - trans wsician/Medical E	X UNPENDED AMEADED, PII, 27, perME, g867, 5/18/07 TT
ox 68760 eath certificate attending phy for use as the b	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year
Box 6: e death cerr the attendii ed for use a	past 12 months? 4 Pregnant at time of death 5 Other (Specify)
P.O. Box 6876 that the death certificat red by the attending pheatched for use as the by Physician/M	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
P.C es that igned be deta	
of Vital Records, P.(ng Physician: The law requires tha the this certificate has been signed aneral director, page 2 should be det no. To Be Completed by	24a. Was an autopsy findings available autopsy prior to completion of cause of
(eco he law ate has age 2 s	performed? death? 1
Vital Rec ysician: The his certificate director, page	25. Was case referred to medical 25. Place or Dearth Check only one)
F Vite	1 Ves 2 No inpatient 2 V ER/Outpatient 3 DOA 4 Noting notine 3 Center.
on of oding Plus. After e funera	27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No
Division Division and or Attendight and Director; led in by the fi ertification	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Division of Division of Signature of Signatu	Suicide 6 Could not be determined (Specify) or Town, State)
3 4 5 5	
To the Ho within 24 To the Fu complete!	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
A.	O.C.M.E. April 28, 2007
9 m	30. Name and address of person who completed cause of death (Item 23a)
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Susan Hogan MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
State Registra	

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2 2007 May Douglas E. Wilson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Gilchrist Center Towson 8. Date of Birth April 21, 1961 If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** 215-80-6362 1 M 2 □ F Yrs 45 Director 5 Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore Essex Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21221 203 Riverside Drive 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2K Married 2 □ No Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 6 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Construction Electrician 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MArion Kirkum Elmer C. Wilson ea/pno/ ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sherry Wilson /wife 203 Riverside Drive Baltimore Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Bayview Crematory 5/3/07 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. MD 21. Signatur of Funeral Service Lice see Hella Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): CANCER /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed and as the burial-tra Due to (or as a consequence of): attending physician if for use as the burial Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No. been signed by the should be detached 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a, Was an autopsy perform certificate Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica tely filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

6701

32. Registrar's Signature

Registrar DHMH 17 Rev 1/2001

State

N. Chales St. Calts. and Zc 204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

11:30am

Birthplace (State or Foreign Country)

10d. Inside City Limits

MD 21221

Approximate Interval Between Onset and Death

ears

Year

Hospice

1 ☐ Yes 2 XNo

Maryland

Baltimore

14. Race - American Indian,

Black, White, etc.

Specify: White

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?

2□ No

1 ☐ Yes

Month

			1 - State Registrar			Ce	rtificate of	f Death		Re	eg. No.	1	
			1. Decedent's Name (First, Middle,	Last)					2. Date of Death 3. Time of Death				
	Physici /Medio		Irma	Collier		Yure	ek			May 2,	2007	Ioai	9:05 A M
	Examir		4a. Facility Name (If not institution, 5708 Merchant	-	nber)		4b. City, Town. Tem	or Location o		4c. County of De Prince			
	Funeral		5. Social Security Number		7. Age (In yrs.	• •	If Under 1 Year Months Day		24 Hrs. 8	B. Date of Birth (Month, Day,	Year)	9. Birth	plece (State or Foreign intry)
	Director		216 14 7170	1□M 2∏F	85	Yrs.	lilloriano Bay			Aug 8,		Mary	
	p z		Usual Residence of Decedent 10a. State 10b. County		10c Ci	ty. Town or Lo	ocation						10d. Inside City Limits
	eho •	5				Camp Sp							1 ☐ Yes 2XXNo
	28e-1	ect	Maryland Prince	George						11	0g. Citizen o	What Cou	inter?
	a or 3	급	5708 Merchan	nt Dood			10f. Zip Code)748			United		
	eath	era	11. Marital Status		edent Ever in U	I.S. 13.	Was Decedent of		igin? (Spec				ican Indian,
10	r Rend	표	1 Never Married 2 Marrie	Armed Fo ad 1 ☐ Yes	rces? 2-7-No		If Yes, specify Cu	iban, Mexicar	, Puerto R	ican, etc.)		ack, White	
ဗ္ဗ	ar', o	à	3 ☐ Widowed 4 ☐ Divorced	If Yes, Giv Year or Da	$e\Lambda\Lambda$		1 ☐ Yes 2 ☐ XN	o Specify:			Spec	ity: W	hite
21215-0036	72 hours after death with the Maryland Instural', or Iteme 23a or 28e-f ehow Orsal Examinat must be notified at	Completed by Funeral Director	15. Decedent' (Specify only highest			16a. Dece	dent's Usual Occ	upation	t of working		16b. Kind of	Business/Ir	ndustry
7	within then the Max	g	Elementary/Secondary (0-12)	College (1	-4or 5+)	life.	DO NOT use reti	red)					
	e filed within al Hygiene. I other then "vent, the Mark	ပိ	12	2		_Real	Estate				Real		e
ğ	lid be fil fental H rked oti	Be	17. Father's Name (First, Middle, L Theordore Co.	ası) 11ier					ers Name (1 Hass	(First, Middle, N	Maiden Suma	ime)	
3	should nd Men marke imatic	٦						1					
, Maryland	ges 1 end 2 should be filed within 72 hours after death with the Marylan it of Heelih and Mental Hygiene. If Item 27 is marked other then "naturat", or Iteme 23a or 28e-1 show or other traumatic event, In Middical Examinat must be notified at		19a. Informant's Name/Relationsh Allen Yurek			5708		nt Roa	ad, Ca	amp Spr			
Baltimore,	of He		20a. Method of Disposition 1 ⚠Burial 2 ☐ Cremation	3 Demoval from		Place of Dispo cemetery, crei	osition (Name of matory or other p	May	7, 20€	D97 :	20c. Location	- City or T	own, State
Ĕ	Pages ment of ant: If It ury or o		4 Donation 5 Other (So			ryland	Veterar	ıs Ceme	etery	-	Che1t	enham	, MD
at	permit. Pag Department Important: I any injury o		21. Signature of Fundral Service	in nsee	theil.	/// 22	2. Name and Add	ress of Facili	ty Lee	runera.	I Home	,Inc	6633 Old
_	40 E E a		70 DIVI		10196		lexandri			<u>`</u>		עניו	0735
		-	23a. Part1. Enter the disease, or o shock, or heart failure. List of	complications that conly one cause on e	aused the dear ach line.	th. Do not ent	ter the mode of d	ying, such as	cardiac or	respiratory arre	est,		Approximate Interval Between Onset and Death
100	Pnysician		Immediate Cause (Final disease or condition	_ a(Cord	JOM.	toward	thy					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consec	quence of):	1	1					
			Sequentially list conditions, if any, reading to immediate	b. — Dua to (or as a consec	nuenna rifle							
7	nsit	를	Cause (Disease or injury	4		(40,000 01).							
Ž.	sertificate be executed ding physicien and se as the burial-transIt	Examiner	that initiated events resulting in death) Last	c. Due to (or as a consec	quence of):							
68760,	sicie ysicie e bur			d									
89	tifical og ph as th	/Medical	1======										
\mathbf{a}	C 2		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pregnirth 2 Feta		∃Ectopic pregnar	ncv			1	ate of deliv	
P.O. Bo	Attending Physician: The law requires that the death certif rdeath. rdeath. ector: After this certificete has been signed by the attending by the tuneral director, page 2 should be detached for use as	Physician	in the past 12 months? 1 ☐ Yes 275 No 9 ☐ Unknown		ant at time of o		Other (specify)				N	lonth	Day Year
ت.	that t ed by deta	A.	Part II. Other significant condition	ns contributing to de	eath but not res	sulting in the u	inderlying cause (given in Part I		23e. Did tob	pacco use co	ntribute to	the cause of death?
ds	puires n sign ald be	d by	HYDOT	ension						1 ☐ Ye	s 2XNo	3 Pro	bably 4 Unknown
ဥ	w require been signature should b	Completed								24a. Was a	n 24b	. Were aut	opsy findings available
2	The la	E								autops	ned?	prior to co death?	ompletion of cause of
ta	an: Tificel	BeC	25. Was case referred to medical					26 Place	of Death /	1 ☐ Yes 2 (Check only on	No No	1 🗆 Yes	2]XNo
\geq	ysici is cer direc	ToB	examiner? 1 ☐ Yes 2 % No	Hospital: 1 🔲 I	npatient 2	ER/Outpatier	nt 3 DOA			e 5 Reside		ther (Speci	ify)
0	neral		27. Manner of □eath 1 Natural 5 □ Pending	28a. Date of	of fnjury th, Day Year)	28b. Time o	f 28c. In			Bd. Describe ho		~	
<u>.</u>	endir sath. or: Af he fu	atlc	2 ☐ Accident investig	ation	,,,	,,		Yes 2	No				
Division of Vital Records,	or Att	Certification:	3 Suicide 6 Could n 4 Homicide determine	ned 200. Flace	of Injury - At h	iome, farm, sti	reet, factory, offic	е	28	Bf. Location (St. City or Town	reet and Nun n, State)	nber or Rur	ral Route Number,
۵	pital ours a eral E		20a Cartilla	Dhusisis T	haat - 4	and a control	h		1-1	-1.4			
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physicien: To the exeminer: On the ba and mann	asis of examination of states.	owledge, deat ation and/or in	n occurred at the vestigation, in my	time, date ar opinion, dea	nd place, an ath occurred	nd due to the ca d at the time, da	ause(s) and r ate and place	nanner as : e, and due :	stated. to the cause(s)
0 1	To the within To the Comp	ž	29b. Signature and titleyof certifier	11				nse number			9d. Date sign		Day, Year)
			1.4da	hima	u m	(D)	DO	2200	999		5/2	12	007
	14.0		30. Name and address of person v	no completed caus	e of death (Iter	m 23a) (Type,	Print)						
	10		Ali Rahimian,	M.D. 7501	Surra	tts Ro	ad #205,	Clint	on, M	ID 2073	35		
12	Sta Registr		31. Date filed (Month, Day, Year)	2007 321R	egistrar's Sign	arure	and I						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** MAI atthe 837 PM 2 2007 /Medical 4b. City 4c. County of Death Town, or Location of Death Racility Name (If not institution, give street and number) Examiner eake Med Center tord 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country)

Michigan Michin 6. Sex 1 M 2 ☐ F **Funeral** Days Min. Months Hours Director 10c. City, Town or Location 10d. Inside City Limits 10b. County show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director tora linator 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Aymed Forces? 1 M Yes 2 □ No If Nes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: ģ white. 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important; if Item 27 Is marked other than "any Injury or other traumatic event, the Mea only Injury or other traumatic event, the Mea Elementa Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Be 2 Informant's Name/Relationship (Tyre. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darlington MD 21034 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Method of Disposition 1 Buniar 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (*Specify*) Aldino 21. Signature of Funeral Service Ligenses ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e cause on each line. 23a. Part1. Enter the disease, or/compshock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Cardio Vescular **Physician** arterio sclerotic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examiner be executed and burial-trar Due to (or as a consequence of): South 131 Seconds, P.O. Box 68760, attending physician Physician/Medical the as use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 201 in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) the 9☐Unknown 9 Unknown has Leen signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy performed? Yes 2 No certificale To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director: After this certifice completely filled in by the funeral director. 25. Was case referred to medical examiner?
1

Yes 2 No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 XER/Outpatient 3 □ DOA 1 Inpatient 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier 1041 sor who completed cause of death (Item 23a) (Type, Print) 30. Name and address of p BERNARD J. 1614 CHURCHVILLE ROAD BELAIR, Md 21015 DME 31. Date filed (Month, Day, egistrar's Signature State 0 Registrar 4 2007

DHMH 17 Rev 1/2001

21202

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 14, 2007 **Physician** РМ 5:44 Frank E. Aldridge, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis if Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/02/1954 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1**X**M 2□F Hours Washington, DC Director 213-66-0898 52 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location a or 28a-f show the notified at 10b. County 1X Yes 2 No Director Anne Arundel Gambrills MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with r than "natural", or Items 23a the Medical Examiner must b USA 21054 2184 Branchwood Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or Ite 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Budget Analyst 12 of the and Mental Hygie 27 Is marked other I traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dorothy de Graffenreid Frank E. Aldridge, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2184 Branchwood Court Gambrills, MD 21054 Patricia McGrath/ Sister other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department o Important: If any injury or once. = 5 Ft. Lincoln Cemetery 04/19/2007 Brentwood, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) NEUMONIA /Medical Due o (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Clease or India) that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical as attending | for use as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should I Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 2 Nio 1□ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 1 Yes 2 No 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural (Month, Day Year) Injury 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendil within 24 hours after death.
To the Funeral Director: A completely filled in by the fu death. investigation 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2001 Medical Parkway 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Reynoldo Lee- Clacer II, MD 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

APR 19

2007

ORIGINAL

			For State Registrar	State of Mar	-	epartmer <i>Certifical</i>			lental Hy	giene Reg. No	ZUUI	14505
			Decedent's Name (First, Middle, La	st)					2. Date of De			3. Time of Death
	Physici /Medic		ANNA	ELIZABET	ГН	ABRA	MS		APRIL	1		2:43 P M
	Examin		4a. Facility Name (If not institution, giv	e street and number)		4b. City	Town, or	Location of Death		40	. County of Death	
			ATLANTIC GENERA			W. De de	BER1				WORCES	
	Funeral		5. Social Security Number 6. S	Sex 7. Age ((In yrs. last birtho	Months		If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	ay, Year,		place (State or Foreign intry)
	Director		219-10-1561 Usual Residence of Decedent		81 Yrs	-			FEB. 16), 1	926 MA	RYLAND
	land ow		10a. State 10b. County		10c. City, Town o	r Location						10d. Inside City Limits
	the Marylan 28a-f ehow	ţ	DELAWARE SUSSEX		SELBY	VILLE						1 ☐ Yes 2X No
	ith the	Director	10e. Street and Number			10f. Zi	p Code			10g. Ci	tizen of What Cou	intry?
	23a c	ai	37811 SWANN DE	RIVE			1997				USA_	
	items items	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S.	 Was Dece If Yes, spe 	dent of Hi ocify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No Rican, etc.)	o-	14. Race - Amer Black, White	
36	s afte	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates:		1 🗆 Yes	2K) No	Specify:			Specify: W	HITE
21215-0036	within 72 hours after death with the Maryland ene. then "netural", or Items 23e or 28e-f ehow the Medical Examinar must be notified at	edt	15. Decedent's E	1	16a. D	ecedent's Usu	ial Occupa	ation		16b. h	(ind of Business/l	ndustry
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2	e filed al Hygi I other vent, I	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle	e, Maide	n Sumame)	
<u>a</u>	should be fand Mental Permarked of	2	CHARLES	MAGEI	RKURTH			MARY		ZABI		VARNICK
√c/ Maryland	s 1 and 2 should be filed I Health and Mental Hyg Item 27 ie marked othe other treumatic event,	9	19a. Informant's Name/Relationship					and Number or Run				
	s 1 and 2 t Health item 27 item 27 is		GEORGE R. VAN FL	EET/SON	20b. Place of D			NDING ROA	AD BIS		ILLE MD ocation - City or	
9-10-15 Baltimore,	Pages nent of h int: if its iry or of		1 Burial 2 □ Cremation 3		cemetery, MEADOW	crematory or	other plac	(e)			•	
9-10- Baltimo	it. Pa intmer rtant njury		4 □ Donation 5 □ Other (Special Service Lice	1-/	MEADOW	22. Name a			/0/	ELL	RIDGE, N	IAKILAND
Ba	permit. Pages Department of Important: If I any injury or ognes.		1 /200 61	2/A				JNERAL HO	ME, SEI	BYV	ILLE, DE	. 19975
83			23a. Part Enter the disease, or com shock, or heart failure. List only	plications that gaus 1	he death. Do no	t enter the mo	de of dyin	g, such as cardiac	or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final	S CASI.							a de maior y de	Onset and Death
	/Medical		disease or condition resulting in death)	a	ppnsequence of)):						
V	Examiner		Sequentially list conditions	Dowel	l Obst	ruch	~					
11926	ם ב	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		consequence of)							
V	ecute and -trans	Examiner	that initiated events resulting in death) Last	c. Severe	consequence of)	2						
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287	icate phys s the	edicai		_ d.								4.0
DX (eath certifi attending for use as	Ž	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		0 Tr .					23d. Date of deli	very
W TH B	death e atte	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☑ No	1 ☐ Live birth 2 4 ☐ Pregnant at ti		3 □Ectopic p 5 □ Other (s					Month	Day Year
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S. S.	requires that the een signed by th nould be deteche	by	Part II. Other significant conditions	contributing to death but	not resulting in t	he underlying	cause giv	en in Part I.	4	tobacco Yes :	/	the cause of death?
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. 77	aw as b	Completed							24a. Wa auto	s an opsy formed?	24b. Were au prior to death?	topsy findings available completion of cause of
IN CE		ខ							1 Yes		o 1 ☐ Yes	212 No
2 2 X	ysician: T is certificat director, pa	B	25. Was case referred to medical examiner?	Hospital:			Oth	26. Place of Dea			- 50	
N SO L	± ± ™	. To	1 Yes 2 No	28a. Date of Injury	28b. Tir		28c. Injur Wor	4 🗆 Nursing n	ome 5 ☐ Hes 28d. Describe		6 ☐Other (Specury occurred	er y)
A B P	ding th.: After a funer	흗	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) Inj	ury M		k? Yes 2 □ No				
(c)	or Attanation deation of Director:	ertification:	3 Suicide 6 Could not l			n, street, facto	ry, office		28f. Location City or To	(Street a	and Number or Ru	ral Route Number,
۵	pitel or A ours after herel Dire- filled in by	Cert	4 Tromode	Dunding, etc.	(арвену)							
	Hospitel 24 hours a Funerel i	edical ((Check only 2 Medical Exa	hysician: To the best of miner: On the basis of e	examination and/							
	훈 들 훈 등	Med	one) 29b. Signature and title of certifier	and manner state	ed	2	9c Licens	e number		29d D	ate signed (Monti	n. Dav. Year)
	Con To		250. Signature and title or certifier	_		2		3612		1	11,700	, , , , , ,
	Br		30. Name and address of person who	completed source of de-	ath (Item 22a) (T	ivne Print)	00				11010	
,	100		ANDREA K. BAIER				., BE	ERLIN, MD	21811			
	St	ate	31. Date filed (Month, Day, Year)	32. Registra								
	Regist	rar	APR 2 0	2007 1	· H	Augas.						

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) APRIL 28, 2007 **Physician** 5:52A M BRITTEN DOROTHY /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner **Allegany** Cumberland Memorial Hospital & Medical Center If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) May 17, 1923 9. Birthplace (State or Foreign 6 Sex 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Months Μ̈́D 1 M 2 □ F 83 219-14-7358 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notifiled at once. 10d. Inside City Limits 10c, City, Town or Location 10b. County 10a. State 1√□Yes 2 □ No Allegany Cumberland MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21502 USA 409 Grand Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: white Completed by 3X Widowed 4 ☐ Divorced 16b Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) own home homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mae Winters Lloyd Winters ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 409 Grand Avenue Cumberland MD 21502 19a. Informant's Name/Relationship (Type. Print) Cumberland 409 Grand Avenue Cheryl Britten daughter Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State 5/3/2007 MD Sunset Memorial Park Cumberland 4 □ Donation 5 □ Other (Specify)

21. Signature of neral Service Licensee ^{22. Name} and Address of Facility Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical **Examiner** Goquentially not conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner the death certificate be executed the burial-tran and Due to (or as a consequence of) physician as attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) P.0. been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 2 No 3 Probably 4 Unknown TUS 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No cate has l CAT 1∐ Yes certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA ို 1 Inpatient 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of D ath Certification: Injury 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2007 April 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D.; SOO MEMORIAL AVE., CUMBERIAND, MD AISOZ

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

name known to physician: BENDER, JOHN HERMAN Baltimore, Maryland 21215-0036 Division or Vital Records, P.O. Box 68760, Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TTEM#24a, perVERB. G867, 574707 WS

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

	-	For State Registrar				Ce	ertificate of	Death		Reg. No.	2017	1 1 1	00
Di		1. Decedent's Name (First, A							2. Date of D Month	Day		3. Time of	
Physici /Medic		John Herm		Bender				1 N (D 1	Apri]		2007 County of Death	4:50	P ^M
Examin		4a. Facility Name (If not insti						or Location of Deat	ın				
		VA Maryland	Healt 6. Se	h Care	System 7. Age (In yrs.	last hirthda		Point If Under 24 Hrs	8. Date of E	Birth	eci.l 9. Birth	place (State o	r Foreign
Funeral Director		5. Social Security Number 204–01–1511	1.	M 2□F		34 Yrs.	Months Days	Hours Min.	11/3/	1922 ^{r)}	Penns	sylvani	.a
and		Usual Residence of Deceder 10a. State 10b. Co			10c. Cit	y, Town or	Location					10d. Inside Cit	ty Limits
Maryl f sho ied a	ō	MD	Harf	ord		Aber	deen					1X Yes	2 □ No
r 28a	irec	10e. Street and Number					10f. Zip Code			10g. Citi	izen of What Cou	intry?	
h with	Funeral Director	514 Windem	ere D	r.			2100)1			U.S.A.		
deat ems	ner	11. Marital Status		Armed F	cedent Ever in U orces?	.S. 10	 Was Decedent of If Yes, specify Cu 	Hispanic Origin? (ទ pan, Mexican, Pue	Specify Yes or I rto Rican, etc.)	No-	 Race - Amer Black, White 		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 □ Never Married 2🏋 3 □ Widowed 4 □ Dive		1 ⊠ Yes If Yes, G Year or I	2 □ No live WWI Dates: WWI		1 ☐ Yes 2 🖾 No					hite	
72 ho natur Jical	eted	15. Dec	edent's Ed	lucation de completed)	16a. De (Gi	cedent's Usual Occi ve kind of work don e. DO NOT use retir	pation during most of wo	orking	16b. K	ind of Business/I	ndustry	
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l be findal Hed of ed of	Be	Herman M.						Grace	Maguire	5			
hould id Me mark matic	7	19a. Informant's Name/Rela	ationship (Type. Print)		19b. Ma	ailing Address (Stree	at and Number or F	Rural Route Nur	nber, City	or Town, State, Z	ip Code)	
nd 2 s Ith an 27 is		Patricia S			pouse)	51	4 Windeme	re Dr.	Aberdee	en, M	21001		
teπ tem other		20a. Method of Disposition			20b.	Place of Dis	sposition (Name of crematory or other p	ace)	Date	20c. Lo	ocation - City or	Town, State	
Page: ent o nt: If I		1X Burial 2 □ Crema 4 □ Donation 5 □ Ot			n State		resby. Ce	- /-	5/07	Abe	rdeen, M	aryland	£
permit. I Departm Importar any Inju		21. Signature of Funeral Se			1		22. Name and Add Tarring- Aberdeen	ress of Facility Cargo Fur	neral Ho	ome, I	P.A.		
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		23a. art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a Coronary Artery Disease Unknown											
Physician		disease or condition	0.00				Disease					unknow	n
/Medical Examiner		resulting in death)			o (or as a conse							unknow	m
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execu n and ial-tra	Examiner	that initiated events c											
rificate be executed ng physician and as the burial-transit	Medical	Ca											
± p ≈	Medi	IE EFRANIE.											
The law requires that the death cer tte has been signed by the attendin page 2 should be detached for use	Physician/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 5 □ Other (specify)											Year
at the	Phy	9 ☐ Unknown Part II. Other significant c	anditions	contributing to	death but not re	eulting in th	e underlying cause	niven in Part I.	23e. D	id tobacco	use contribute to	the cause of	death?
ires the	b	Fait ii. Other significant c	Onditions	contributing to	dodin barrior ro			,	1	☐ Yes 2	2	robably 4 🛚	Unknowr
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sicial certif	Be	25. Was case referred to r examiner? 1 ☐ Yes 2 ZNo	nedicai	Hospital:	Inpatient 2	TEB/Outpa	atient 3 DOA	Yhar:			6 ☐Other (Spe	ecify)	
Phys r this eral di	5.	27. Manner of Death		28a. Da	te of Injury	28b. Tim	ne of 28c. In				ury occurred		
th. th. After funera	ţi		Pending investigation	,	onth, Day Year)	Inju		☐ Yes 2 ☐ No					
ter dea irector	Certification:		Could not I determined	200. FIG	ace of injury - At ilding, etc. (Spe		, street, factory, offi	e		on <i>(Street a</i> Town, <i>St</i> a	and Number or R te)	ural Route Nu	mber,
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, I	Medical Ce	29a. Certifier 1 🖫 C (Check only 2 M	ertifying P edical Exa	aminer: On the	the best of my kee basis of exami	nowledge, on ation and/	death occurred at the or investigation, in n	e time, date and pla ny opinion, death o	ace, and due to ccurred at the ti	the cause(ime, date a	(s) and manner a nd place, and du	s stated. e to the cause	e(s)
o the ithin o the	Mec	29b. Signature and title of	certifier	4.14	2 /		29c. Lic	ense number			ate signed (Mon	th, Day, Year)	
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241		30. Name and address of Rene DellosSa	person who	o completed ca	ause of death (It	em 23a) (Ty	_(pe, Print) Health Ca	are Syste	em Perr	y Poi	.nt, MD	21902	
4 7 0	toto	31. Date filed (Month, Day	Year)	11.1.	Registrar's Sig	nature							
S Regis	tate strar	MAY (4 20	107	Registrar's Sig	To A	DIMEL!						

DHMH 17 Rev 1/2001

State Registrar Charles

31. Date filed (Month, Day, Year)

mD

32. Registrar's Signature

		·	T = For State Registrar	State of	Maryland / De <i>C</i>	partment of Fertificate of		Я	leg. No.	14510
	Physici	an	Decedent's Name (First, Midd	die, Last)				2. Date of Dea Month	th Day Yea	
	/Medic	cal		BRADFORD		the City Town	al and a d Bank		22, 2007	3:40 p ^M
4	Examir	er	4a. Facility Name (If not institution				r Location of Deat! ke City	1	4c. County of De	
	Funeral		Hartley Hall 5. Social Security Number		Age (In yrs. last birthda	y) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9.5	Birthplace (State or Foreign
	Director		218-58-0116 Usual Residence of Decedent	1□M 2 K 3F	103 Yrs.	Months Days	Hours Min.	7/10/19	903 Vi	rginia
	yland		10a. State 10b. Count	у	10c. City, Town or	Location				10d. Inside City Limits
	the Marylan 28a-f show	ţō	MD Worces	ster	Pocomoke	City				1X Yes 2 □ No
	or 28	Olre	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
	a 23a	ral	1006 Market St			21851		" "	USA	- Contactor
	irer de	Funeral Director	11. Marital Status 1 □ Never Married 2 □ Ma	12. Was Deced Armed Forc 1 ☐ Yes 2	es?	 Was Decedent of F If Yes, specify Cub 	fispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	Black, W	merican Indian, hite, etc.
980	urs af	þ	3 ☑Widowed 4 ☐ Divorce	If Vas Give	_	1 ☐ Yes 2 No	Specify:		Specify:	white
215-0036	within 72 hours after death with the Maryland ene. then "natural", or Itema 23e or 28e-f show he Moulcol Examilier mast be multified at	Completed		ent's Education est grade completed)	16a. De	cedent's Usual Occup ve kind of work done	pation during most of wor	tkina	16b. Kind of Busine	ss/Industry
121	vithln ne. han	du	Elementary/Secondary (0-12)		or 5+)	. DO NOT use retire	d)		5.00	
d 21	Hygie ther t		17. Father's Name (First, Middle). Last)	HOME	maker	18 Mother's Nar	ne (First Middle	Domestic Maiden Sumame)	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic event, the Marical Examiner mast be notified at angeloge.	To Be	William Parks	, ===-,			Lydia		maraon damano,	
ary	and Name		19a. Informant's Name/Relation	ship (Type, Print)	19b. Ma	iling Address (Street	and Number or Ru	ıral Route Numbe	r, City or Town, State	a, Zip Code)
	and 2 ealth m 27 I		H. Coston Glade	ding (Son-in-		Cedar St.	, Pocomo			
altimore,	Pages 1 nent of H int: If iter		20a. Method of Disposition 1 ■ Burial 2 □ Cremation	3 □Removal from St	comotoni c	position (Name of rematory or other pla	1	Date	20c. Location - City	or Town, State
Ë	t. Partmen		`4 □Donation 5 □Other (Whatcoat (The state of the s		the plant of the second		, Maryland
Bal	permit. Departr Imports any Inju		21. Signature of Funeral Service	ADean		103 Linder	n Ave., I	Pocomoke	fessional As City, MD	sociation 21851
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that caust only one cause on each	used the death. Do not sh line.					Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. EN		ALZHE	IMER'S	DEM	ENTIA	
	Examiner		,	Due to (or	as a consequence of):					
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or	as a consequence of):					-
	cuted hr ransit	Examiner	that initiated events	C						-
90,	sate be executed oblysician and the burial-transit		resulting in death) East	Due to (or	as a consequence of):					
8760,	cate b	Physician/Medical		d						
9 x	death certifica attanding ph d for use as th	/Me	IF FEMALE:	23c. If yes, outco	ome of pregnancy				23d. Date of	delivery
Box	death a attar d for u	clar	23b. Was decedent pregnant in the past 12 months?	1☐Live birt	h 2 Fetal death	3 □Ectopic pregnanc 5 □ Other (specify) _	y		Month Month	Day Year
P.0	that the de led by the a detached f	hys	9 Unknown	9□Unknow	m					
	8 50	Ď	Part II. Other significant condit	tions contributing to dea	th but not resulting in the	underlying cause giv	ven in Part I.	23e. Did to		e to the cause of death? Probably 4 Dunknown
Records,	w require been si should b	letec						24a. Was a		
Re	'siclan: The law cortificate has t lirector, page 2 s	Completed						autop perfor	sy prior to death	
ta	an: T tificat tor, pa	Be Co	25. Was case referred to medic	al			26 Place of Dea	1 ☐ Yes ath (Check only or	2 5≲ No 1 □ Y	es 2XNo
of Vital	Physician: this certificatal director, I	To B	examiner? 1 ☐ Yes 2 → Yo	Hospital: 1 🗆 Inc	patient 2 ER/Outpa	ient 3□ DOA Ct			ence 6 □Other (S	(pecify)
0	ng Ph fter th ineral		27. Manner of Death 1 Matural 5 ☐ Pend	28a. Date of (Month,	Injury 28b. Time Day Year) Injur			, , , , , , , , , , , , , , , , , , , ,	ow injury occurred	
Sio	Attending r death. ector; After by the fune	catle		tigation		M 1	Yes 2 ☐ No			
Division	or At	Certification;		mined 286. Place of	f Injury - At home, farm, , etc. (Specify)	street, factory, office		28f. Location (S City or Tow		Rural Route Number,
	spital ours a neral		29a. Certifier 1 Certify	ing Physician: To the b	est of my knowledge de	ath accurred at the ti	me date and place	and due to the o	rauso(s) and manner	as stated
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	(Check only 2 Medica one)	If Examiner: On the bas and manne	is of examination and/or	investigation, in my	opinion, death occu	irred at the time, o	date and place, and c	due to the cause(s)
	To the comp	Σ	29b. Signature and the of certifi	7		29c. Licens			29d. Date signed (Mo	
)			John	m)		0.0	1062172		4/23/2	2007
6	AI		30. Name and address of person SHARAD & S	n who completed cause	of death (Item 23a) (Type TMARICET gistrar's Signature	Perint) Pecone	OKE CITY	MD 3	21851.	
	Sta Registi		31. Date filed (Month, Day, Yea APR 2 3	2007	gistrar's Signature	barle				
			AFR & e		Man 2- 1-					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** atherive 08:58 AM F006 TOU /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner war ces ter HUSPITAL Berlin 21811 renera MD Hlon If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Days Months 1 □ M 2 Hours 213-38-9356 66 Director Nov. 11, 1940 ΝÝ Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified a 1 ☐ Yes 2 X No Director MD Worcester Berlin 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö 5 Dockside Dr. 21811 USA or itema 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. ☐ Yes 2 ☐XNo f Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: naturel Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "nu any injury or other traumatic event, the Medit page. Elementary/Secondary (0-12) College (1-4or 5+) Secretary Health Department 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Sven Aage Christensen Mary Baldwin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William R. Balk (husband) 5 Dockside Dr., Berlin, Md. 21811 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Cape Henlopen Crem. 4-24-2007 4 ☐ Donation 5 ☐ Other (Specify) Frankford, DE 22. Name and Address of Facility The Burbage Funeral Home 21. Signature A Funeral Service Licensee 108 William St., Berlin, Md. 21811 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Freenhallt **Physician** /Medical Examiner metastatio Brain Concer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician and s the burial-transit Exam once 2 Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 4☐Pregnant at time of death o 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 21 Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has 2500 1 Yes Je Sar 1 Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 15 mpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2200 2 2 ER/Outpatient 3 DOA Director: After the 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Hospital or Attending Natural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) after 4 Homicide within 24 hours a To the Funerel [Medical 29a Certifier Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the crasses) and manner as stated (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Fo the 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) 64645 mpleted cause of death (Item 23a) (Type, Print) BAID 9733 alt MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 23 Registrar 2007

07-02896

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Aaron Brown	1- For State Registrar	aryland / Department of Certificate of		Reg. N	. 2007	14512
Physician/ Medical Examine	Decedent's Name (First, Middle,Last) Aaron Matthew	Brown		2. Date of Death Month Day April 15, 2007	/ Year	3. Time of Death 2355 hrs
	4a. Facility Name (if not institution, give street 1195 Madison Street	and number)	b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 6. Sex 219-76-9696 1X M 2	7. Age (In yrs. last birthday) F 44 Yrs.	If Under 1 Year If Under 24Hrs. Months Days Hours Min.	July 14,	M/DD/YYYY) 9 Birth 1962 Foreign Cour	Maryland
w апу	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Locati	on		1	10d Inside City Limits 1 X Yes 2 No
the Maryland n or 28a-f show any siffied at once. Director	Maryland Anne Arunde. 10e. Street and Number 1371 Tyler Avenue	l Annapolis	10f. Zip Code 21401		Citizen of What Count USA	
er death with ti or items 23a must be noti	11. Marital Status 1 X Never Married 2 Married A 1	rmed Forces? If Ye Yes 2 X No	S Decedent of Hispanic Origin? (Spes, specify Cuban, Mexican, Puerto		14. Race - America White, etc. Specify: Black	
2 hours afte "natural", I Examiner		est grade completed) 16a. Decedent during mo	Yes $2 \overline{X} $ No specify: It's Usual Occupation (Give kind of working life. DO NOT use reting the Driver	(her	Specify: Dados No. Kind of Business/Inc Crucking	
21215-0036 build be filed within 72 hour Mental Hygene marked other than "natu c event, the Medical Exa		Truck		(First, Middle, Maide	en Surname)	
MD 212 nd 2 should be slith and Ment m 27 is mark aumatic ever	19a. Informant's Name/Relationship (Type, Pr Elaine Jackson - Sis		Address (Street and Number or Fortle Ave., Balti	Rural Route Number, Lmore, MD	City or Town, State, 2 21201	Zip Code)
- 트 교 등 교 근 .	4 Donation 5 Other Specify:	noval from State crematory or oth Bestgate	Memorial Park	9/2007 A	c. Location - City or T	
Balt permit Depart Import injury	21. Signature of Funeral Service Licensee	29	ම්ලිසුම් මේම දැන්වීම් S Fu 1973 Solomons Isla	and Rd., E	Edgewater,	MD 21037
Physician /Medical Examiner		hot Wound of Head	ne mode of dying, such as cardiac o	r respiratory arrest, s	hock, or heart	Approximate Interval Between Onset and Death
i.	Sequentially list conditions, b.	(or as a consequence of): (or as a consequence of):				
ted Jansit Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	(or as a consequence of):				
ou, e be executed ysician and burial - transit	d. UNPENDED AME	NDED				
tox 6876 eath certificat eath certificat for use as the		December of death	tal death 3 Ectopic pregna		23d. Date of delivery Month Da	ay Year
, P.O. B res that the d signed by the be detached by the d by the be detached by Phy		outing to death but not resulting in the u	inderlying cause given in Part I.		oo use contribute to the	
tal Records, cian: The law requires certificate has been signetor, page 2 should be Completed				24a. Was an autopsy performed 1 Yes 2	prior to co	opsy findings available ompletion of cause of 2 No
Vital I ysician: his certifi director,	25. Was case referred to medical examiner?	1 Inpatient 2 ER/Outpatient	26 Place of Death (Check of Donald Other) 3 DOA Other, Nursin		idence 6 🗸 Other:	Scene
Division of Vital Recipital or Attending Physician: The Jours after death. Bernal Director: After this certificate iffled in by the funeral director, page	27 Manner of Death	a. Date of Injury OUND: Day,Year) pr 15, 2007 28b. Time of Information FOUND: 2345 hrs		28d. Describe how i Subject shot	njury occurred	
Division or Attending within 24 hours after death. Within 24 hours after death. To the Funeral Director: After completely filled in by the fune edical Certification:	3 Suicide 6 Could not be determined (5	se. Place of Injury - At home, farm, stree Specify) Sidewalk		or Town, State) 1195 Madison Stro	eet, Annapolis, MD	-
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in beddical Certific	Check only 1 Certifying Physician: To one) 2 Medical Examiner: On the and m	the best of my knowledge, death occur be basis of examination and/or investigat anner stated.	ion, in my opinion, death occurred a	at the time, date and p	place, and due to the	cause(s)
	296. Signature and title of certifier	llar	29c. License number O.C.M.E.		d. Date signed (Mont	n, ∪ay, Year)
\	30. Name and address of person who completed Carol Allan, MD Assistant Me		Street, Baltimore, MD 2120	1		
State Registra		Registrar's Signature	W			
DHMH 17 Rev 1/2001		ORIGINA	L			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Day Year **Physician** RALPH LLEWELLYN BOYER APRIL 2007 19 :20 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** CIVISTA MEDICAL CENTER LAPLATA CHARLES | Months | Days | Hours | Min. | March 124 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Formatty) | March 12, 1917| | PENNSYLVANIA | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 → M 2 □ F Yrs 212-18-6019 90 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show aminer must be notified at 1 Yes 2 No Director MARYLAND CHARLES WALDORF 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 11080 WEYMOUTH COURT 20603 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. be filed within 72 hours atter ntal Hygiene. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 X No 21215-0036 Specify. Specify: BLACK Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) **8TH GRADE** College (1-4or 5+) ORDNANCE WORKER FEDERAL GOVERNMENT 18. Mother's Name (First, Middle, Maiden Surname) land 17. Father's Name (First, Middle, Last) Be is marked JAMES ELMER BOYER ROSA STEWART BOYER ပ Mary 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1 and 2 s PHELICIA O. BOYER / WIFE 2570 MARSHALL HALL ROAD, BRYANS ROAD, MARYLAND 20616 important: if item 2 any Injury or other once, imore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 Eurial 2 Cremation 3 Removal from State MARYLAND VETERANS CEMETERY APRIL 24, 2007 CHELTENHAM, MARYLAND 4 □ Donation 5 □ Other (Specify) Son ture of Funer (Cervice) ensee THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 LYDIA C. THORNTON JOHNSON MO0583 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Meta-stat Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the death certificate be executed and burial-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 physician by Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23h Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy perform certificate Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day or Attending 1 Natural 2 Accident 5 Pending investigation s after dea. ral Director: Aft 1 Yes 2 No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide within 24 hours a To the Funeral I 1X Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2001 10061652 MD

18481 State

State Registrar 31. Date filed (Month, Day, Year)

APR 2 3 2007

ATUL KATYAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11350

PEMBROOK SQ SUITE 304 WALDORF, MD 20603
32. Registrar's Signature

07-03006 Brent G. Bowling

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Brent G. Bowling April 19, 2007 1131 hrs **Medical Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Route 5 & Route 488 Waldor Charles 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Hours Months Days Director Country) 215-96-4529 1 X M 2 43 July 5,1963 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No MD Charles Charlotte Hall Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho no other tramnatic event, he Medical Examiner must be noffield at once. Director 10e. Street and Number 10g. Citizen of What Country? 10051 Trinity Church Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces White, etc. Never Married 2 X Married 2X No Yes White Widowed Divorced If Yes. Give Year Yes 2 X No specify: Specify: 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Benjamin Franklin Bowling, Sr. Phyllis Guy Bowling 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jennifer Bowling/Wife Trinity Church Road, Charlotte Hall, MD20622 20c. Location - City or Town, State 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, Date crematory or other place) 1 X Burial 2 Cremation Removal from State Department of Important: St. Mary's Newport 4/24/07 Charlotte Hall,MD Donation 5 Other Specify 21. Signature of Funeral Service Licensee M00945 22 AREHARTESECTIONS FUNERAL HOME, P.A. Ect St. Mary's Ave. La Plata, MD 20646 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician een Onset and failure. List only one cause on each line. /Medical a. Positional Asphyxia complicating Atherosclerotic Cardiovasacular Disease Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and - transit The law requires that the death certificate be executed Physician/Medical attending physician or use as the burial -UNPENDED AMENDED Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Day Year Fetal death 2 past 12 months' Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. <u>۾</u> 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed peen 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has death? performed certificate Yes 2 1 🗸 Yes 26.Place of Death (Check only one) the Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Be examiner? Other: Hospital: 1 Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 ✔ Other: Scene this 1 V Yes No 28a. Date of Injury (Month, Day,Year) FOUND: After 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: Driverof dump truck in collision with fixed object FOUND: Natural 1 Yes 2 No Director: d in by the f Pending hours after death. Apr 19, 2007 1116 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) Route 5 & Route 488, Waldorf, MD (Specify) Major Road / Highway To the Funeral Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. April 20, 2007 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD

State Registra

	•	For State Registrar	State of M	laryland		rtment of H tificate of L		nd Mental H	ygiene Reg. No	7 11 11	14515
Physicia		1. Decedent's Name (First, Middle, Las	12.5					2. Date of Month	Death Da (l	y Year	3. Time of Death
/Medica Examine		4a. Facility Name (If not institution, give	street and number			4b. City, Town, or West	Location of 1	Death		. County of Dea	,
Funeral Director		5. Social Security Number 6. S		ige (In yrs. Ia	ist birthday) Yrs.	If Under 1 Year Months Days	If Under 24	Hrs. 8 Date of	Birth Dav. Year.	9. Bir	hplace (State or Foreign ountry)
g		Usual Residence of Decedent						37 237		IIII	
anylar •how	_	10a. State 10b. County			Town or Lo						10d. Inside City Limits 1 ☐ Yes 2 ☐ No
the M	Director	MD Anne Aru	ındel	West	River				100 C	tizen of What Co	21
with with		595 Owensville Ro	- a d			10f. Zip Code	770		10g. Ci		ournity!
death me 23	Funeral	11. Marital Status	12. Was Deceden	t Ever in U.S	6. 13. V	A	778 spanic Origir	n? (Specify Yes or Puerto Rican, etc.)	No-	USA 14. Race - Ame	
Ind 21215-0036 be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-f show event, Ita Medical Enach or invitie J at	Dy ru	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed XX Divorced	Armed Forces 1 Yes 20 If Yes, Give Year or Dates	No		Yes, specify Cuba		Puerto Rican, etc.)		Black, White Specify:	e, etc. White
2 hour		15. Decedent's Ed	Jucation		16a. Deced	ent's Usual Occupa	ation		16b. H	Kind of Business	/Industry
215 thin 7	Completed	(Specify only highest gra	de completed) College (1-4or	5+)	(Give) life. L	kind of work done of OO NOT use retired	furing most o)	of working			
d 212 filed withi Hygiene. other there	5	12			Admini	strative.				borator	У
S data b	0 20	17. Father's Name <i>(First, Middl</i> e, <i>Last)</i> Frank Vadala						s Name (First, Midd 1 Saddler	fle, Maidei	n Sumame)	
ire, Maryla s 1 and 2 should if Health and Mer item 27 is marks other treumatic	i	19a. Informant's Name/Relationship (7						or Rural Route Nur			
re, M 1 and 3 Health tem 27	-	20a. Method of Disposition	Friend	20b. Pla	ace of Dispos	sition (Name of		West Riv	-	ocation · City or	
Pages Pages ment of ant: If it		1 ☐ Burial XXX Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		8	-	natory`or other place matory		/19/2007	Ba1	timore,	MD
Baltime permit. Pag Depertment Important: I eny injury o		21. Signature of Funeral Service Inter	see					Hardesty Annapolis			e, P.A.
Physician		23a. Part1. Enter the disease, or companies shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that cause one cause on each	ed the death.	Do not ente	er the mode of dying	g, such as ca	ardiac or respiratory	arrest,		Approximate Interval Between Onset and Death Month S
/Medical Examiner		resulting in death)	Due to (or a	s a consequ	ence of):						31,000,00
bed nsit	Examiner	Sequentially list conditions, if any, leading to mined accause. Enter Underlying Cause (Disease or injury	Deato (or s	в а сопведи	ence of):						
8760, sate be executed hysicien and the burial-transit	al Exar	that initiated events resulting in death) Last	Due to (or a	s a consequ	ence of):						
	edicai		d								
death cert	Physician/me	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant : 9 □ Unknown	2 Fetal	death 3 🗌	Ectopic pregnancy Other (specify)			-	23d. Date of de Month	livery Day Year
		Part II. Other significant conditions o	ontributing to death	but not resul	iting in the un	derlying cause give	en in Part I.	23e. Di	d tobacco	use contribute to	the cause of death?
cords, w requires been sign should be	tea by							1[☐Yes 2	. □ № 3,220	obabły 4 🗆 Unknown
He la	Completed								topsy rformed?	prior to death?	utopsy findings available completion of cause of
VITAI viclen: I certifice rector, p	e l	25. Was case referred to medical examiner?		*			26. Place o	f Death (Check on)	-		
Of V Physic r this c	2	1 ☐ Yes 2 No	Hospital: 1 Inpat		R/Outpatient		4 🗆 14013	ing Home 5X Re			cify)
ding P	0	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inj (Month, D	ay Year)	28b. Time of Injury	28c. Injury Work	rat ⊲? Yes 2.⊟No	28d. Describ	e how inju	iry occurred	
DIVISION Of VITA To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: Atter this certific completely filled in by the funeral director.	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Ir	njury - At horestc. (Specify)	ne, farm, stre	eet, factory, office	.03	28f. Location	(Street a		ural Route Number,
DIV To the Hospitel or A within 24 hours after To the Funeral Dire completely filled in b	edical	29a. Certifier 1 Certifying Ph (Check only one)	ysician: To the bes niner: On the basis and manners	of examination	vledge, death on and/or inv	occurred at the time	e, date and binion, death	place, and due to the control occurred at the time	ne cause(s e, date an	and manner and place, and due	s stated. to the cause(s)
o the	₩ P	29b. Signature and little of certifier	and mainers	nateu.		29c. License	number		29d. Da	ate signed (Moni	h, Day, Year)
->-0		· Mr K	he MI)			DOG	1643	79	4	119/200	7
4		30. Name and address of person who	in Rhee	(IM	90	O Bertze	k R	d Sule	300	Anypal	7 ., MD 21401
State Registra		31. Date filed (Month, Day, Year) APR 19 2	007 32. Figis	trar's Signati	tre	week					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 16, 2007 1:00 a^{M} April Clement Theodore Cooper /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1220 East West Hwy. #821 Silver Spring Montgomery If Under 1 Year | If Under 24 8. Date of Birth (Month, Day, Year Oct. 26, 1 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours 1⊠M 2□F Vrs Oct. 1930 76 Miamí Director 264-38-3169 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f ehow Examiner must be nutified at 1x Yes 2 No Director Silver Spring MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural" ~ " any injury or other traumatic average. ō 20910 U.S.A 1220 East West Hwy. #821 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. African Armed Forces:
1 ⊠Yes 2 □ No
If Yes, Give 1952 —
Year or Dates: 1954 1 ☐ Never Married 2X Married 1 Yes 2X No Specify. Š American 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Law Attorney 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Benjamin Leon Cooper Louise Bethel 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Nannie C. Cooper / Wife 1220 East West Hwy. #821 Silver Spring, MD 20910 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Rock Creek Cemetery | April 21, 2007 Washington, DC 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility McGuire Funeral Service 21. Signature of Ineral Service Licensee 7400 Georgia Ave., N.W. Washington, DC 20012 housson nochi 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cancer of Lungs disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-transit and Due to (or as a consequence of) Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No ঠ 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2X No certificate After this certific funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 ☐ Nursing Home 5 🛣 Residence 6 ☐ Other (Specify) 3 DOA 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 28c. Injury al Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 5 Pending 1 Natural 1 TYes 2 No investigation 2 Accident 281. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide

Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760, Division of Vital Records, within 24 hours after death.

To the Funeral Director: Af To the

the Maryland

Certification: To Medical

28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Usearer MO April 18, 2007 D16619

Registrar

Corazon Soares, M.D. 31. Date filed (Month, Day, Year) APR 2 0 2 2 0 2007

8240 Professional Pl., Landover, MD 20785 Registrar's Signature

07-02845 Robert Arthur Ch	niche	Please Type	or Print in Bla of Maryland /					•	gible.	
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		I- For State Registrar	Of Maryland /		ficate of L	F.	IIG MEIR		eg. No. 200	7 1451
Physicia	ın/	Decedent's Name (First, Middle,La						Date of Dea Month	Dav Year	3. Time of Death 0125 hrs
Medical Exami		Robert 4a. Facility Name (if not institution, gi	Arthu:	r		iches	ter or Location of	April 14, 2	2007 4c. County of Deat	
		S/B 17051 Aquasco Rd.	vo stroot and namber,			Brandywir			Prince Georg	
Funeral Director		5. Social Security Number 6. \$ 220-15-2772	Sex 7. Age	(In yrs. last	t birthday)	If Under 1 Y Months Da	ear If Under ays Hours	Min.	th(MM/DD/YYYY) 9. Bit Forei	thplece (State or gn Virginia puntry)
Å	į	Usual Residence of Decedent								10d. Inside City Limits
ow any		10a. State 10b. County		10c. City, 10	own or Location					1 X Yes 2 No
ryland ra-f sh rt once	횽	Maryland Princ 10e.Street and Number	<u>e George</u>		Aqua	SCO 10f. Zip Code			0g. Citizen of What Cou	
vith the Maryland s 23a or 28a-f show a notified at once.	Director	18200 Richard	Allen St	root		206			USA	
with t ns 23a		11. Marital Status	12. Was Decedent		13. Was	Decedent of	Hispanic Origi	n? (Specify Yes or No	- 14. Race - Ame	rican Indian, Black,
death wi or items	Funeral	1 Never Married 2 Marrie	1 Yes 2	X No				Puerto Rican, etc.)	White, etc.	
s after ral",	2		d If Yes, Give Year or Dates:	15		es 2X		ind of work done	Specify: Wh:	
2 hour "natu	Completed	15. Decedent's Education (Specify (Elementary/Secondary (0-12)	College (1-4 or 5				ife. DO NOT u		16b. Nind of Business.	industry
036 ithin 7 ne. rethan	nple	12			Skill	ed La	borer		Chopp I	nc.
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene, and of Health and Mental Hygiene and: If item 27 is marked of ther than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once		17. Father's Name (First, Middle, Las	t)				18. Mother's	Name (First, Middle,		
121 Id be fi fental narked event,		Howard 19a. Informant's Name/Relationship (Tuna Deint \	Chi	chest		Jane		mber, City or Town, Stat	Lentz
MD 2 id 2 shoul ilth and N m 27 is n numatic	-	Howard Chiches	•	ar.					shington I	- 1
e, N I and J Health item	ı	20a. Method of Disposition	_	20b. Pla	ace of Disposition	on (Name of		Date Date	20c. Location - City o	r Town, State
Pages ent of nt: If		1 XBurial 2 Cremation 3 4 Donation 5 Other Specification		ILE I	icoln 1		ial	4/20/2003	 Suitland	d,Maryland
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after de Department of Health and Mental Hygiene. Inhoportant: If item 27 is marked other than "natural", or injury or other traumatic event, the Medical Examiner m.	1	21. Sign up Funeral Service Lice			22. Na	me and Addr	ess of Facility	Adams Fur	neral Home	DA
		23a. Part I. Epiter the disease, or con		191	20	605 A	guaso	Road Agi	iasco, Mary	zland20608
Physician /Medical		failure. List only one cause on e	each line.	the death. L	o not enter the	mode of dyli	ng, such as ca	rdiac or respiratory an	rest, snock, or neart	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	Multiple Injuries Due to (or as a conse	equence of):						- Doda
		Sequentially list conditions,								
	Ē.	if any, leading to immediate Due to (or as a consequence of):								
ed	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	equence of):						
execute an and al - tran		UNPENDED	AMENDED							
50, te be e	Medi	IF FEMALE:	23c. If yes, outcor	ne of pregna	ancy				23d. Date of delive	rv
687(ertifica ding ph	an/N	23b. Was decedent pregnant in the past 12 months?	1 Live birth	, 0	· —	l death	3 Ectopic	pregnancy	Month	Day Year
Box 68760, re death certificate be execute the attending physician and red for use as the burial - tra	Physician/Medical	1 Yes 2 No 9 Unknow	/n 9 Pregnant at Unknown	time of	5 Oth	er (Specify)				
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tal Records, P.O. cian: The law requires that th certificate has been signed by ector, page 2 should be detach	d by						-		es 2 V No 3 Pro	
ords w requ	Completed							24a. Was	psy prior to	utopsy findings available completion of cause of
Rec The la cate hi	E								ormed? death?	res 2 No
ital F ician: s certifi	Be	25. Was case referred to medical examiner?	Hospital:				Other	Check only one)		
f Vi	욘	1 Yes 2 No 27. Manner of Death	Inpatie 28a. Date of Inju		R/Outpatient 28b. Time of In		njury at Work?	Nursing Home 5	Residence 6 Oth	er: Scene
onding ath.	Ei Ei	1 Natural 5 Pending	Apr 14, 2007		0117 hrs	· 1 -	Yes 2	Passenger	auto fixed object	collision
Division of Vital Records, tal or Attending Physician: The law requires after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be	fical	2 ✓ Accident Investigat 3 Suicide 6 Could no	28e Place of in	jury - At hom	ne, farm, street	, factory, offic	e building, etc			tural Route Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burit	Certification:	4 Homicide determin		al Street		- 0		S/B 17051 A	guasco Rd., Brandyw	rine, MD
he Hos n 24 h ne Fun nletely									use(s) and manner as sta e and place, and due to	
To the within To the comp	Medical	29b. Signature and title of certifier	and manner stated.	ununi aile			ense number		29d. Date signed (M	
		70/ -11	1/1	,			C.M.E.		April 14, 2007	
	}	30. Name and address of person who	completed cause of d	eath (Item 2	(3a)				<u> </u>	
\ .										

State 31. Date filed (Month, Day, Year) 3 2007

Registrar

Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

32. Rigistrar's Signature

			For State Registrar	State of M	Marylar	•			ealth a		ental H	ygiene Reg. No	211117	14518
	50		Decedent's Name (First, Middle, Last	it)							2. Date of D	eath		3. Time of Death
	Physicia		EUNA ELIZABETH	I HOTTAN	וח כח	DETM				20.	Month pril	17.		2400hr
	/Medic Examin		4a. Facility Name (If not institution, give			WDIN	4b. City	, Town, or	Location of		PILL		. County of Dea	
	LAGIIIII	ie.	410 S. Kaywood	Drive			Sal	isbu	ıry			W	icomic	:0
	Funeral		5. Social Security Number 6. S	ex 7		last birthday)	If Und	r 1 Year	If Under	24 Hrs. Min.	8. Date of B (Month, D Dec.	lirth	9. Bi	rthplace (State or Foreign ountry)
	Director		216-14-2522	□w X (X)F	89	Yrs.	Months	Days	Hours	MIII.	Dec.	19,	1917	Wirginia_
	pr ,		Usual Residence of Decedent		100 0	ly. Town or Lo								10d. Inside City Limits
	anyla shov	2	10a. State 10b. County			•								1 Yes 2 No
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	vith ti	Director	10e. Street and Number 410 S. Kaywood	Drivo				p Code 804				-	itizen of What C	ountry ?
	within 72 hours after death with the Maryland ene. Than "natural", or iteme 23a or 28a-f show he Medical Examinar must be notified at	ral			nt Francis II	C 112			innania Ori	inin2 (Con	naifu Van ar N	L	14. Race - Am	erican Indian
	iten iten	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decede Armed Force	s?	.5.	If Yes, sp	ecify Cuba	n, Mexicar	n, Puerto	cify Yes or N Rican, etc.)	*0-	Black, Wh	
36	i, or	by F	3 ☐ Widowed 4 ★ Divorced	1 □Yes 2√ If Yes, Give Year or Date	s:		1 🗌 Yes	2 X No	Specify:				Specify: Wh	ite
ş	tura stura		15. Decedent's Ed			16a. Dece	dent's Us	ual Occupa	ation			16b. l	Kind of Business	s/Industry
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27.	r tha	E 0	8	College (1-4d) J+)	Mana	gmei	ıt				Hea	lthcar	`e
ַ	illed wi Hygien other th	Be C	17. Father's Name (First, Middle, Last)								(First, Midd			
<u>a</u>	lid be lental rked c	To B	Frank Williams	}				Ī	Edna	Eli	zabet	th A	nderto	n
ar Z	2 should be and Mental is marked of raumatic av		19a. Informant's Name/Relationship (Type, Print)		19b. Maili	ng Addre	s (Street a	and Numbe	er or Rura	I Route Num	ber, City	or Town, State,	Zip Code)
Ž	and 2 belth a n 27 is		Edna Walls/ da	ughter		410	S. I	ayw	ood i	Driv	re, Sa	alis	bury,	MD 21804
ē,	es 1 a of He fitam r oths		20a. Method of Disposition		1 .	Place of Dispo	matory or	other place	e)		ate		ocation - City o	
Ë	Pages nent of nnt: If its ury or o		4 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification)	Removal from Sta ()	te Be	thany	Met	ch. (Cem	4/21,	/07	Poc	omoke C	ity, MD
altimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Heelih and Mental Hygiene. Importent: If item 27 is marked other than "natural; or iteme 23a or 28a-1 show any injury or other traumatic avant, the Medical Examinar must be notified at once.		21. Signature of Funeral Service Licer		-	2:	2. Name	nd Addres	s of Facili	ity	3 40	2 - 1		
m	De E E		Much D	Donn				_		_	-		den Ave.,	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that ceus	sed the dea	th. Do not en	ter the mo	ede of dym	g, such as	cardiac c	r respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final			R	1.1	1. /	Janco	د				Onset and Death
ř.	/Medical		disease or condition resulting in death)		as a consec		cad	er	anci					CM25
H	Examiner		•	_										
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	cuted od ransli	Examiner	Cause (Disease or injury that initiated events	С.										
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m	deat ne ett	Sicie	in the past 12 months? 1 🗆 Yes 2 🚜 No	4□Pregnan 9□Unknow	t at time of d		Other (.	Month	Day Year
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	The law requires thet the death certific tte hes been signed by the ettending p age 2 should be detached for use as	by F	Part II. Other significant conditions of	/		sulting in the u	ınderlying	cause give	en in Part I	l.				to the cause of death?
ğ	w require been si should t	P	Atrial F	16-11/9	400						1/2	Yes 2	2 □ No 3 □ F	Probably 4 Unknown
၁	aw re ss be 2 sh	ple									24a. Wa	as an topsy	24b. Were a	autopsy findings available completion of cause of
ŭ	The lav	Completed									per 1 ☐ Yes	rformed?	death?	
<u>ta</u>	ician: Th certificate rector, pag	Bec	25. Was case referred to medical						26. Place	e of Death	(Check only	-		
Division of Vital Records,	Attending Physician: r death. sctor: After this certifici by the funeral director.	To	examiner? 1 ☐ Yes 2 💇 No	Hospital: 1 ☐ Inpa	atient 2] ER/Outpatie	nt 3 🗆 [Oth	er: 4 🗆 Ni	ursing Ho	me 5 5 Re	sidence	6 □Other (Sp	ecify)
0	ng Pt ter th		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of I (Month,	njury Day Year)	28b. Time o	of	28c. Injun World	y at k?		28d. Describ	e how inj	ury occurred	
<u>ō</u>	andir ath. or: Af	Certification:	2 ☐ Accident investigation	1			М		Yes 2]No				
<u>\frac{8}{2}</u>	I or Atter de Directo	tific	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of	Injury - At h	iome, farm, st	reet, facto	ry, office				(Street a		Rural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funaral Director: After this certific completely filled in by the funeral director.	Cer								7				
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	To the h within 24 To the F complete	Medical	one)	and manner								,		
	Te Too	2	29b. Signature and title of certifier				2	9c. Licensi		01		1	ate signed (Moi	
			10/1/	Jun				N 3	249	80		4	11910-	/
-	212		30. Name and address of person who	completed cause of	of death (Ite	m 23a) (Type	Print)			C /	1	C244=1%	100	
L	3A3		PRREILY SEOKI	esside De	Mics	beel I A	X7	ibe	101	20/15	buy	MD	21801	-
		ite	31. Date filed (Month, Day, Year)	32, Reg	strar's Sign	ature	Land							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar 4/26/07, M.S., Kent Co. Amended#8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Yeer Month **Physician** 9:350 Edna 04 2007 Darah DORSEN 20 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** worton 25646 Charlestown En T ruc If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Days **Funeral** Months Hours 1 ☐ M 2 🗹 F 215-05-9174 Usual Residence of Decedent 3 20 mD Director 1916 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Funeral Director KENT worton mD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21678 CHARLES TOWN COURT SA 238 death v 2564le 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 | Yes 2 E-No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 5 Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: ¿ BLACK þ 3 ₩Widowed 4 Divorced 'natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 7 in Yractical Vurse Mursin .. Pages 1 and 2 should be filed w tment of Health and Mental Hygis tent: if Item 27 is marked other t ijury or other treumatic event, Ib 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mosses a . Koberts 19a. Informant's Name/Relationship (Type, Print) 25646 Charles Town Court Worton, MD 21678 WALTEN - Daughter TETTI Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town. State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Apitol Department of Importent: If eny injury or once. 22. Name and Address of Facility KENNEYN DAIL TUNERAL SCRUCE 4/28/07 ' 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Lucioze 821 w. ST. annapolis, md 21401 23a. Pur. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Arheiner disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Deby but. Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a co sequence Examiner sician and e burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a O 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I I be det Records, ð 2 0 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? death? certificate of Vital Hospitel or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Yes 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 2 this 28d. Describ how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death Certification: After Division Natural 5 Pending 2 No 1 Tes death. investigation 2 Accident Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide hours after within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 Church HIRd Chestertow, Umg 21620 Delboy MD 6
32. Registra Signature 6602 Rederick 31. Date filed (Month, Day, Year) State APR 2 6 2007 Registrar

DHMH 17 Rev 1/2001

	1- State of Maryland / Department / Departm	artment of Health and N rtificate of Death	lental Hygie Reg.	0007 11505							
cian	Decedent's Name (First, Middle, Last) AYANNA		2. Date of Death Month	Day Year 20 2007 2222 M							
dical iiner	4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center	4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel							
al or	5. Social Security Number 103–58–1750 Usual Residence of Decedent 6. Sex 1 M 2 XF 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye May 14,	1972 9. Birthplace (State or Foreign Country) New York							
ctor	10a. State 10b. County 10c. City, Town or Lo	Annapolis		10d. Inside City Limits 1 X Yes 2 □ No							
al Director	10e. Street and Number 600 Admiral Drive Apt. 510	10f. Zip Code 21401	10g.	Citizen of What Country? USA							
by Funeral	1 ☐ Never Married 2 🔀 Married 1 ☐ Yes 2 ☐ XNo	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Pueric 1 ☐ Yes 2X No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black							
Completed	(Specify only highest grade completed) (Give Elementary/Secondary (0-12) College (1-4or 5+)	dent's Usual Occupation kind of work done during most of work DO NOT use retired) gistered Nurse	ing 16b	o. Kind of Business/Industry Private							
To Be C	17. Father's Name (First, Middle, Last) Gerald Sablo	Ruth	e (First, Middle, Maid Ann	Williams							
	Marc Duhaney (Husband) 600	ng Address (Street and Number or Run Admiral Dr. #51 position (Name of matory or other place)	0 Annapo								
	4 □ Donation 5 □ Other (Specify) Hillcrest 21. Signature of Funeral Service Licensee 2	Mem. Gardens 4/2 2. Name and Address of Facility Jon 1001 Benning Road,	dan Funer	•							
edical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as i consequence of): Due to (or as a consequence of): Language Left Basal Granglia Bload Due to (or as a consequence of): Language Left Basal Granglia Bload Due to (or as a consequence of): Language Left Basal Granglia Bload Due to (or as a consequence of): Language Left Basal Granglia Bload Due to (or as a consequence of): Language Left Basal Granglia Bload Due to (or as a consequence of): Language Left Basal Granglia Bload Due to (or as a consequence of):										
Physician/Me		⊒Ectopic pregnancy ⊒ Other (specify)		23d. Date of delivery Month Day Year							
ed by Ph	Part II. Other significant conditions contributing to death but not resulting in the confidence of the significant conditions contributing to death but not resulting in the confidence of the significant conditions contributing to death but not resulting in the confidence of the significant conditions contributing to death but not resulting in the conditions contributing to death but not resulting in the conditions contributing to death but not resulting in the conditions contributing to death but not resulting in the conditions contributing to death but not resulting in the conditions contributing to death but not resulting in the conditions contributing to death but not resulting in the conditions contributing to death but not resulting in the conditions contributing to death but not resulting in the conditions contributing to death but not resulting in the conditions contributing to death but not resulting in the conditions contributing to death but not resulting in the conditions contributing to death but not resulting to the conditions contributed by the conditions contributed by the conditions contributed by the conditions conditions contributed by the conditions conditions contributed by the conditions contribu	inderlying cause given in Part I.	23e. Did tobaco	co use contribute to the cause of death?							
Completed by	Lupers		24a. Was an autopsy performed 1∐ Yes 20								
ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No	nt 3 DOA Other: 4 Nursing Ho	th (Check only one) ome 5 ☐ Residence 28d. Describe how i	e 6 □Other (<i>Specify</i>) Injury occurred							
Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At home, farm, st building, etc. (Specify)		City or Town, S								
Medical	29a. Certifier (Check only one) Check only one) Check only 2 Medical Examiner: On the basis of examination and/or in and manner stated. 29b. Signature and title of certifier	th occurred at the time, date and place, investigation, in my opinion, death occur 29c. License number	red at the time, date	e(s) and manner as stated. and place, and due to the cause(s) Date signed (Month, Day, Year)							
	30. Name and address of person who completed cause of sum from Sa) (Type, July 41. Joseph - Halletta MD PAC	DO043371 Print) 9501 Met. S ANNAPOCES	ICAC PA	4/20/07							
State Strar	31. Date filed (Month, Day, Year) APR 2 3 2007 APR 2 3 2007	a month of	1 1113	, ~17~1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) April 18. 2007 **Physician** 3:10 P Maurice Ε. Dennison /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince George's Hillhaven Asst. Living Nursing & Rehab. Ctr. Adelphi Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 1(1/9/19/1901) 5. Social Security Number **Funeral** Months Days Hours Min. 92 577-09-8717 1 → M 2 □ F Yrs Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or 28e-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nant of Health and Mental Hygiene.
sait. If item 27 is marked other then "neturel", or items 23a or 28e-f show and I or other treumatic event, Ita Maufical Ex. nither until be notified at 1 ☐ Yes 2KNo Waldorf Charles Directo Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20603 2900 McDaniel Road Be Completed by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Gardner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Fmma Payne James Millard Dennison 101 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20603 2900 McDaniel Road Waldorf, Maryland Linda L. Dennison / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition

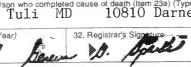
1 Burial 2 Cremation 3 Removal from State permit. Pages 1 Department of H Importent: If ite eny injury or ot once. Suitland, Maryland Cedar Hill Cemetery April 23,2007 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Seprice Licenses 22. Name and Address of Facility George P. Kalas Funeral Home PA 6160 Oxon Hill Road Oxon Hill, Maryland 20745 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ARRYTHMIA **Physician** /Medical Due to (or as a consequence of) Examiner MYOCARDIAL INFARCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4□Pregnant at time of death 5 Other (specify) signed by the a ☐ Yes 2 ☐ No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 3 Atherosclerotic Heart Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Chronic Obstructive Lung Disease 24a. Was an autopsy performed? Yes 2 No has page 2 1 ☐ Yes 2 ☐ No certificate 1 Yes To the Hospital or Attending Physician: within 24 hours after death.
To the Funerel Director: After this condition 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 🔀 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 ☐ Yes 2 🗓 XNo 2 completely filled in by the funeral 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Momicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of Raman of death (Item 23a) (Type, Print) 10810 Darnestown Road completed cause of death

10

31. Date filed (Month, Day, Year)



MD

State Registrar #202

Gaithersburg, MD

20878

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician М 15, 2007 Alaya Ty'Nese Drayton 7:35 April /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 1770 Silk Cotton Way Gaithersburg Montgomery If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 6. Sex Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days 1 □ M 2 N F Director 6 June 10, 2000 062-90-4086 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show an "natural", or Items 23a or 28a-f show Me Aical Examiner must be notified at Maryland Montgomery Gaithersburg 1 X Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 1770 Silk Cotton Way 20877 United States Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. and the table and Rems 23 ant: If Item 27 is marked other than "natural", or Items 23 ury or other traumatic event, the Me Acal Examiner must 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 ☑ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Student Elementary School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Richard Drayton Cynamon Craig ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynamon Craig (Mother) 1770 Silk Cotton Way, Gaithersburg, MD 20877 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any Injury or ot cometery cjematory or other place) April 24, 1 ☐ Burial 2 X Cremation 3 ☐Removal from State 4 □ Donation 5 □ Other Spenty matory 2007 Bronx, New York
22. Name and Address of Facility DeVol Funeral Home, 2007 21. Signature of Funeral Service 10 East Deer Park Drive, Gaithersburg, MD 20877 23a. Fart 157 e, the disease, or complications that caused the beath. Do not enter the mode of dying, such as cardiac or respiratory arrest, so kilo eart ailure. List only one cause on each line.

Immeriate Corise Final disease, or condition resulting in death)

a. Spinocerebellar Ataxia Type 7 Physician /Medical Due to (or as a consequence of) Examiner b. Cerebellar Degeneration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of Loss of Mobility death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1□Yes 2🙀 No ed by the a detached f 9□Unknown 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, should be Feeding Intolerance 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? Candidal Esophagitis 24a. Was an this certificate has ral director, page 2 autopsy performed' 1 ☐ Yes 2 ☐ No 1☐ Yes 2☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1X Natural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

31. Date filed (Month, Day, Year)

APR 2 0 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

29a. Certifier

(Check only one)

Medical



State Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

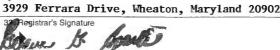
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 12:00 p M Dona1d Eugene DeLong April 16, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 14313 Northwyn Drive Colesville Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Days Hours Months 1 X M 2 □ F Director 92 160-01-4772 May 23, 1914 Pennsylvania Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location a or 28a-f show t be notified at 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No Director Maryland Montgomery Colesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a the Medical Examiner must b 14313 Northwyn Drive 20904 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 K No þ 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 3 Salesman 5 4 1 Computers 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 George DeLong Florence Kintzer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14313 Northwyn Drive, Colesville, Maryland 20904 Betty DeLong - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 nent of h ant: If ite 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Department or Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Crematory 4/20/2007 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc.
11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Myelin 1.6 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Hypertensive Cardiovascular Disease 2 years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) law requires that the death certificate be executed the burial-trag Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical as IF FEMALE use 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ Diabetes Mellitus Type 2 1 ☐ Yes 2 k No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy perforn or Attending Physician; funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA Other: 4 Nursing Home 5 X Residence 6 Other (Specify) ို 1 ☐ Yes 2 😿 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 1 X Natural 5 ☐ Pending investigation 1 Yes 2 No after death 2 ☐ Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital o within 24 hours aft To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D12121

BALVA

State Registrar 31. Date filed (Month, Day, Year) APR 2 0 2007

George Sengstark, M.D.,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



April 17, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar AMEND#7,8,perINF5/1/07,EMW,McCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Patricia Μ. Doonan 16, /Medical April 2007 2:30 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death 9704 Cable Drive Kensington Montgomery 8. Date of Birth (Month, Day, Year) 54 5. Social Security Number 6. Sev last birthday If Under 1 Year If Under 24 Hrs. **Funeral** Birthplace (State or Foreign Country) Months Days 1 M 2 X F Hours Min. Director 578-62-4984 Hawaii Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 28a-f show a or 28a-f show be notifled at 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No Maryland Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a must a 9704 Cable Drive Funeral 20895 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Race - American Indian permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner. Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No Specify: Caucasian þ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Travel Agent Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Leo Doonan Jeanne Colbert 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel A. Doherty / Brother 9704 Cable Drive, Kensington, Maryland 20895 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Crematory 4/19/2007 Brentwood, Maryland 21. Signature of Funera Service Aceasee 22. Name and Address of Facility Simple Tribute Funeral and Cremation Center 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Iter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, short, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat - ause (Final disease or condition resulting in death) **Physician** Ovarian Cancer 5 years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause United and Indian that initiated events resulting in death) Last Examine Due to (or as a consequence of): the burial-tran Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🔀 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 \$\ Residence 6 \ Other (Specify) Certification: To 1 ☐ Yes 2 ☒ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation Injury 2 Accident 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

P.O. Box 68760, or Vital Records, After this

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Joonan,

the

Baltimore, Maryland 21215-0036

certificate be executed or Attending Physician: completely filled in by the funeral To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A

Medical

State

Registrar

29a. Certifier (Check only one)

M.D.

29b. Signature and title of certifier

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

D45880

04/18/2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Leon C. Hwang, 31. Date filed (Month, Day, Year)

APR 20 2007 1396 Piccard Drive, Rockville, MD 20850 egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physici<u>an</u> April 18 2007 Robert Elie Dufour 8:15A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert 2014 Nostalgia Drive St. Leonard | Months | Days | Hours | Min. | S. Date of Birth | Month, Days | Hours | Min. | June | 15 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 ☐ F 69 1937 578-48-2979 New Hampshire Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at Calvert Maryland St. Leonard 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20685 United States 2014 Nostalgia Drive Funeral permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" once. 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 → Married 1 Tyyes 2 ☐ If Yes, Give Year or Dates: 2 □ No Specify: white 1 ☐ Yes 2 No 54 - 57Specify: 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 retail sales retail 17. Father's Name (First, Middle, Last) Elie C. Dufour 18. Mother's Name (First, Middle, Maiden Surname) Marie Jeanne Lavore Be 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlotte M. Dufour- wife 2014 Nostalgia Drive St. Leonard, MD 20685 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Highlands April 23 2007 Port Republic, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Rausch Funeral Home 4405 Broomes Is. Rd. Port Republic MD 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Lung Cancer vears /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 □**X**o 1 ☐Yes 2 ☐ No 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one) Other: 4 Nursing Home 5XX Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No

The law requires that the death certificate be executed burial-tran Box 68760. physician attending properties Division or Vital Records, P.O. rector, page 2 s Hospital or Attending Physician: dir.

with the Maryland

death v

28a-f show

after death.

Director: /

To the Hospital of within 24 hours af To the Funeral Discompletely filled i 0+1

6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

29c. License number 29d. Date signed (Month, Day, Year)

D 0059061

April 18 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

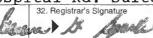
Patel 110 Hospital Rd. Suite 210 Prince Frederick MD 20678

State Registrar

Medical

31. Date filed (Month, Day, Year) APR 1 9 2007

29b. Signature and title of certifier



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2 Day O **Physician** 0641 M ALTON S. ENNIS 0 /Medical 4c. County of Death Eacility Name (If not inglitution, give street and number) Examiner enter ledical Wicomico BUSBURE eninsula egiona If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 X M 2 □ F 220-12-1037 79 2-8-1928 MARYLAND Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2X No Director DELAWARE SUSSEX DAGSBORO 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 27080 GUM TREE ROAD 19939 US Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No WHITE Specify. Completed by Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) WASTEWATER DEPT EMPLOYEE SUSSEX COUNTY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WILLIAM G. ENNIS BLANCHE HUDSON ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: if item 27 is any Injury or other tra BEATRICE ENNIS/ WIFE 27080 GUM TREE RD, DAGSBORO, DE. 19939 20b. Place of Disposition (Name of cemetery, crematory or other place) PRINCE CEORGE S CEMETERY 20a Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Crem 3 ☐ Removal from State 4-22-07 DAGSBORO, DELAWARE 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility MELSON FUNERAL SERVICES, LTD. THATCHER ST, FRANKFORD, DE. 19945 21. Signature of Fanera Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part1. Enter the disease, o shock, or heart failure. Immediate Cause (Final **Physician** ACUTE INFERIOR MYOCARDIAL INFARCTION disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** CORONARY ARTERY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner that the death certificate be executed physician and s the burial-trans CARDIOGENIC SHOCK that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. HEART Physician/Medical ETE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown CHRONIC OBSTRUCTUE PULMONARY DISEASE Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an ARCINOM A autopsy 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ဥ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Division or Vital Records, To the Hospital or Attending within 24 hours after death To the Funeral Director:

Dil 10

DHMH 17 Rev 1/2001

Registrar

Medical

29a. Certifier (Check only one)

rakarl 31. Date filed (Month, Day,

29b. Signature and title of certifier

la APR 23 200

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

614-Easlern mo trar's Signature

1 V Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D425

29d. Date signed (Month, Day, Year)

21801

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Wilcis Spencer Freeland, Sr. 5:10 P M Apr 16, 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death Examiner Calvert Prince Frederick 1195 Hallowing Point Road 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign
Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1**X** M 2□ F 219-12-3528 Yrs. 94 Maryland Dec 19, 1912 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10h County 10c. City, Town or Location 10d. Inside City Limits MD Prince Frederick 1 ☐ Yes 2X No Calvert Director 10e. Street and Number 10g. Citizen of What Country? 10f, Zip Code 1195 Hallowing Point Road 20678 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction 8 Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Emma Smith Spencer Freeland 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Brenda Johnson /Daughter 3814 Glen Avenue Baltimore, MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 04/21/07 Prince Frederick, MD Carroll Western Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facilit 21. Signature of Funeral Service License Sewell Funeral Home 1451 Dares Beach Road Prince Frederick, MD 20678 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** DISSEMI disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, learning to immoduate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consecution of Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed g physician and as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No ۵ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No I Director: A 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 🛨 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 30. Name and a bear of person who completed cause of death (Item 23a) (Type, Print) Jonathan Lowenthal, M.D. Prince Frederick, MD 20678 31. Date filed (Month, Day

State Registrar . Registra

s Signature

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** April 15, 2007 Maurice Ferguson 8:09 A. M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Southern Maryland Hospital Prince Georges Clinton If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 XM 2 ☐ F Months Hours 577-06-6006 Director 40 October 11,1966 Washington,DC Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 X Yes 2 □ No Directo Maryland Prince Georges **Greenbelt** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9330 Edmonston Road; Apt. 203 20770 **United States** permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23s any injury or other traumatic event, the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) D. C. Dept. of Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Recreation Recreation Specialist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Aaron Cornelius Ferguson Evelyn Francis Zeigler 19a. Informant's Name/Relationship (Type. Print) (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20770 9330 Edmonston Road; Apt, 203; Greenbelt, Maryland Janice Maria Willis Ferguson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State April 21,2007 Washington, D. C. 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Glenwood Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility R. N. Horton Company Morticians, Inc. 21. Signature of Funeral Service 600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part1. Enter the disease, or complications that cause. the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Introten Myo carchel **Physician** Hute /Medical Due to (or as a consequence of): **Examiner** arten Coronany Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner as the burial-transit and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Feta! death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?
Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Ves 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1328

32. Registrar's Signa

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31. Date filed (Month, Day, Year

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Southern avenu SE Sout 310 Winhington DC 20032

			1- For State of Maryland / [Registrar	Department of Health and Non-		giene 007	1,529
П	Physic	ian	1. Decedenl's Name (First, Middle, Last)		2. Date of Dea Month	th Day Year	3. Time of Death
1	/Medi		Elizabeth A. Gould		04	18 2007	11:26 AM
	Examir	ner	4a. Facility Name (In ot institution, give street and number)	4b. City, Town, or Location of Death	•	4c. County of Death	
			5. Social Security Number 6. Sex 7. Age (In yrs. last bir	CECITON thday) If Under 1 Year If Under 24 Hrs.	B Date of Birth	Cec.1	
	Funeral Director		320.03.9151 10M 200 F 84	Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day)	Year) 9. Birthi	place (State or Foreign intry)
	and **		Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location		1.	10d. Inside City Limits
	r 28a-f show	0					1 Ø Yes 2 □ No
	28a	Director	10e. Street and Number	10f. Zip Code	1	0g. Citizen of What Cou	·
	death with the Maryland me 23a or 28a-f show rmust be notified at		439 CHURCH ST	21913		USA	
	deatl	Funeral	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Spilf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Americ	
٥	J within 72 hours after death with jene. r then "natural", or teme 23a or the Medical Exattal not must be		1 Never Married 2 Married 1 Yes 2 1 No	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	Rican, etc.)	Black, White,	etc.
9500-61	ural',	d by	3 Wildowed 4 Divorced Year or Dates:			Specify: SA	ck
<u>ဂ</u>	"nat	Completed	(Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of work) life. DO NOT use retired)	ing	16b. Kind of Business/In	dustry
7	with ene. then	m o	Elementary/Secondary (0-12) College (1-4or 5+)	crker (Thetory)	8	21KTon Tire	. makes lac
0	Hyg other ent,	0	17. Father's Name (First, Middle, Last)	18. Mother's Name			COERS GIVE.
land	Aenta Aenta Aenta Trkad Tic ev	To B	Joseph Ringgold	mary S	Tanley		
ary	should and Men s marka umatic		1.2. Informant's Name/Relations ip (Type, Print) 19b.	Mailing Address (Street and Number of Rura	al Route Number	, City or Town, State, Zip	Code)
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o e	ges 1 t of He If item or oth		20a. Method of Disposition 20b. Place of cemeter. 1 ▼Burial 2 □ Cremation 3 □ Removal from State	Disposition (Name of y, crematory or other place)	Date	20c. Location - City or To	own, Slate
Ě	permit. Pages Department of I Important: If it any injury or o		1 5 Dental 2 Gordination 5 Girlemoval notin State	22. Name and Address of Facility KE	1.07 0	VORTON MD	
Saltimor	permit. Pag Department Important: any injury o			Decide the Land Co. March 1997			RAI SERVICE
	7 D 7 4 0		pepe O. Challey wxo26	1821 W. ST. CLANAPOST	is, mo	21401	
			23a. Paint 1. Ent the disease, or complications that chused the death. Do n hock, or heart failure. List only one cause on each line.	ot enter the mode of dying, such as cardiac of	or respiratory arre	est,	Approximate Interval Between Onset and Death
	hysician		Immediale Cause (Final disease or condition resulting in dealh)	al Vascula	_ Y):	50.0	Onset and Death
	/Medical Examiner		Due to (or as a consequence of	f):			
ш	*	er	Sequentially list conditions if any, leading to immediate hue to (a a a consequence of				
1	ansit	Examiner	cause. Enter Underlying Cause (Disease or injury				
5	be executed sician and burial-transit		resulting in death) Last Due to (or as a consequence of	f):			
The learned that the door configuration is	physician and the burial-tra	dlcai	d				
0	attending ph	Med	IF FEMALE:				
	ittend or us	hysiclan/Me	23b. Was decedent pregnant in the past 12 months? 1□Live birth 2 □ Fetal death	3 ☐Ectopic pregnancy		23d. Date of delive	*
5	the a	ysic	1 Yes 2 No 4 Pregnant at time of death	5 Other (specify)		Mortui	Day Year
	ed by the detached	0.	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I	23e Did tob	acco use contribute to the	ne cause of death?
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5	been s	Completed			-		
<u>פ</u>	page 2 s	ш			24a. Was an autopsy perform	y prior to con	psy findings available npletion of cause of
		e Cc	25. Was case referred to medical		1□ Yes 2	Yes 1 ☐ Yes	2[] No
Dhveiden:	s certifica	O B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Out	26. Place of Death		nce 6 Other (Specify	
5 6	er this ieral dii	ı.	27. Manne Death 28a. Date of Injury 28b. Ti	me of 28c. Injury at 2		w injury occurred	,
5	ath. rr: After ne funer	atlo	1 Patural 5 Pending (Month, Day Year) In 2 Accident investigation	ury Work? M 1 ☐ Yes 2 ☐ No			
1	iracto	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - Al home, fan building, etc. (Specify)	n, street, factory, office	28f. Location (Str. City or Town,	eet and Number or Rura. State)	Route Number,
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The Hospital or Attending	within 24 hours after death. To the Funerel Diractor: completely filled in by the fu	edical	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, check only one) 2 Medicel Exeminer: On the basis of examination and and manner stated	death occurred at the time, date and place, a for investigation, in my opinion, death occurre	and due to the car and at the time, da	use(s) and manner as st te and place, and due to	ated. the cause(s)
o the	ithin of the comple	Mec	one) and manner stated. 29b. Signature and tille of certifier	29c. License number		d. Date signed (Month,)	
ř	3 ⊢ ŏ			UN MODELL	11/9	4/22/	7
~	3)	-	30/Name and address of person who completed cause of death (Item 23a) (1	voe. Print)	7/1	1100	
. 2	5	(6 lovia Simonson MD 11	West Hilst	Sito	302 El	Stan MD 2195
	Stat		21 Date filed (Meath Day Vand)		CULL		7
	Registra	ar	APR 2 4 2007	A STATE OF THE STA			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death J. **Physician** April 18, 2007 Margaret Gillespie 11:00 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince George's 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 11/20/1918 Months Days 1 □ M Hours 88 240-12-3952 North Carolina Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Manyland nent of Health and Mental Hygiene.
and: If Item 27 is marked other than "natural", or items 23a or 28a-f show and: If Item 27 is marked other than "natural", or items 23a or 28a-f show and: If Item 27 is marked other than "natural" or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits Director Maryland Prince George's 1 ☐ Yes 2\ No Oxon Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be 120 Balmoral Drive East 20745 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2XXXNo Specify Specify. Completed by 3 Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker In Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Malcolm . Jernigan Venie Ellen Tew 2 19a. Informant's Name/Relationship (Type. Print)
James R. Gillespie / Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 120 Balmoral Drive East Oxon Hill, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Department o Important: If any Injury or Resurrection Cemetery 04/23/2007 4 □ Donation 5 □ Other (Specify) Clinton, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home PA 21. Signatur Funeral Sept Licerises u 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** neuman /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner death certificate be executed burial-trar Due to (or as a consequence of): P.O. Box 68760. physician the as esn. IF FEMALE If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 🖾 No Day 4□Pregnant at time of death 5 Other (specify) ed by the 9 Unknown signed h Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has page 2 autopsy perform Physiclan: 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Hospital or Attending 5 ☐ Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation after death by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide filled in within 24 hours at To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Ty

APR 23 2007

32. Registrar's Signature

931 ory E. Gildea <u>1</u> -	Please Type or Print in Black Indelible Ink. Ensure All 4/19/07 cmh State of Maryland / Department of Health and Me for State Amend# 9 per FH AACO Health Certificate of Death Amend# 5	ntal Hygiene Per PH 4/27/07 CMH Reg. No. 3. Time of Death
Physician/	Decedent's Name (First, Middle,Last)	Month Day Year 2020 hrs April 16, 2007
aminer	Gregory E. Gildea 4b. City, Town, or Location	on of Death 4c. County of Death
4	Facility Name (if not institution, give street and number) 41. State St. 44. City, Town, or Location Annapolis	Anne Arundei
	The Are (la vrs. last hirthday) If Under 1 Year If U	nder 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign PA
Funeral 5	Social Security Number 217–56-3379 579–70–4451 1xxm 2 F 52 Yrs. Months Days Ho	urs Min. 10/30/1954 Country) USA
		10d. Inside City Limi
1 1	Da. State 10b. County 10c. City, Town of Eccasion	1XX Yes 2 1
show age.	MD Anne Arundel Annapolis	10g. Citizen of What Country?
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at once, injury or other traumatic event, the Open To Be Completed by Funeral Director	De. Street and Number	USA
3a or Odiffee	411 State St.	Origin? (Specify Yes or No- 14. Race - American Indian, Black,
or items 23	1. Marital Status Armed Forces? Armed Forces?	ican, Puerto Rican, etc.)
or its	1 Plyorged If Yes, Give Year 1 Yes 2 X No spe	
ural"	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (County only highest grade completed) 17b. Decedent's Education (Specify only highest grade completed)	
2 hou	Elementary/Secondary (0-12) College (1-4 or 5+)	Research & Developme
5-0036 ed within 72 hours lygiene. other than "natu the Medical Exan	1 10 M	other's Name (First, Middle, Maiden Surname)
Hygie Lother Co	7. Father's Name (First, Middle, Last)	Audrey Helen O'Neil
1121 Idibe fil Mental I marked event,	10h Mailing Address (Street and	Number or Rural Route Number, City or Town, State, Zip Code)
Should and M ris m ratic e	Christopher Gildea Brother 8742 Carriage H	ills DR. Columbia, MD 21040
mand 2 and 2 lem 2 lem 2 traum	20b. Place of Disposition (Name of cemete	
Ore	1 Burial 2 X Cremation 3 Removal from State Metro Crematory	4/18/2007 Baltimore, MD
ti. Partunen ortant	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of F	Facility Hardesty Funeral Home, P.A.
Bal permi Depa Impe	23a. Part I. Enger the disease, or complications that caused the death. Do not enter the mode of dying, suc	re. Annapolis, MD 21401 h as cardiac or respiratory arrest, shock, or heart Between Onset
edical Examiner transit Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	
xecuto n and I - trai	UNPENDED AMENDED	
tal Records, P.O. Box 68760, rian: The law requires that the death certificate be executerificate has been signed by the attending physician and ector, page 2 should be detached for use as the burial - transfer of the state of the burial - transfer of the state of	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Pregnant at time of death 5 Other (Specify)	Ectopic pregnancy 23d. Date of delivery Month Day Yea en in Part I. 23e. Did tobacco use contribute to the cause of dea
O. Bc at the dea I by the z	Part II. Other significant conditions contributing to death but not resulting in the underlying cause give	1 Yes 2 No 3 Probably 4 V Unk
P.O.	Chronic alcoholism	24a. Was an 24b. Were autopsy findings av prior to completion of cau
Records, In The law requires ficate has been significate has been significant because the second sec		performed? death?
law has		1 Yes 2 No 100 -
0 5 5 00		of Death (Check only one) Other'4 Nursing Home 5 Residence 6 Other: Scene
I Re		
/ital Recaysician: The his certificate director, page	examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	at Work? 28d. Describe how injury occurred
of Vital Recipe Physician: The other this certificate ineral director, page	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	
ion of Vital Rectending Physician: The lacth. On: After this certificate by the funeral director, page	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	es 2 No 28f. Location (Street and Number or Rural Route Numb
vision of Vital Reor or Attending Physician: The Unter death. Director: After this certificate in by the funeral director, page	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	es 2 No
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Division of Vital Re- To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, page	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office but (Specify) 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, and manner stated. 29b. Signature and title of certifier O.C.N	28f. Location (Street and Number or Rural Route Number or Town, State) te and place, and due to the cause(s) and manner as stated. death occurred at the time, date and place, and due to the cause(s) e number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Thomas Elbert Greene 2007 16, April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 416-14-4023 8, 88 Director Feb. 1919 Alabama Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show notified at Maryland Montgomery Gaithersburg 1 XYes 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be 403 Russell Avenue, #313 20877 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene.

Is marked other than "natural", or iter 1 XYes 2 No Worl If Yes, Give Year or Dates: War II 1 ☐ Never Married 2 X Married 2□No World altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Insurance Underwriter Insurance Company traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Robert Greene Sarah Frances Hewitt ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a ant: If item 27 is ury or other tra Marie Greene_(Wife) 403 Russell Avenue, #313, Gaithersburg, MD 20877 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan 20a. Method of Disposition 20c. Location - City or Town, State April 20. 1 ☐ Burial 2 IXCremation 3 ☐ Removal from State Department of Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) Crematory 2007 Alexandria, Virginia 21. Signature of Funeral Service 22. Name and Address of Facility DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, Maryland 20877 23a. P. rt1. Enter the disease, or complications that caused the sock, b. heart failure. List only one cause on each line. Immedia also (Fihr) disease or condition resulting in death) th. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betwe No W **Physician** Trac /Medical (r as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or s a Examiner law requires that the death certificate be executed as the burial-trai Due to (or as a consequence of): P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably ใUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an autopsy perform Yes funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 ER/Outpatient 3 □ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation Year) (Month, Day Injury death. 1 ☐ Yes 2 ☐ No 2/ Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1011

State

Registrar

Medical

Nicole S. 31. Date filed (Month, Day, Year) APR 20 2007

30. Name and ddress of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature/and title of certifier

(Check only one)



2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Type of Time in L	rack indelible lik.	LIISUIE AII	Cobles Ale L	egi
State of Marylan	d / Department of H	oalth and Me	ntal Hygiana	

			1 - For State Registrar	State of Mai	-	artment <i>rtificate</i>					Reg. No.	, m, in any	14533		
	Physici	an	1. Decedent's Name (First, Middle, Las							2. Date of De Month	Day		3. Time of Death		
	/Medi	cal	IRENE MASON GR. 4a. Facility Name (If not institution, give			4b. City, To	over or l	Location o		pril	18,	2007 County of Death	2:15A M		
1	Examir	ner	Hartley Hall N		me	Pocor						rceste			
	Funeral		5. Social Security Number 6. S	ax 7 Age	(In yrs. last birthday)	If Under 1		If Under 2	24 Hrs. 8	B. Date of Bir (Month, Da	rth av. Year)	9. Birth	place (State or Foreign		
	Director		213-14-1109		81 Yrs.	INIGHANO	Juyo	110010		04/23	3/19	25 Mar	yĺand		
	rland ow		10a. State 10b. County		10c. City, Town or Lo	ocation				<u> </u>			10d. Inside City Limits		
	Mary B-1 sh	tor	MD Worces	er	Pocomoke	e City	7						1 Yes 2 No		
	or 28	Olre	10e. Street and Number			10f. Zip C					10g. Citi	zen of What Cou	untry?		
	s 23e	eral	10 Somerset Ave	-		2185			-:=2 /0			SA 14. Race - Amer	ican Indian		
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other then "natural", or Items 23e or 28a-1 show important: If item 27 is marked other then "natural", or Items 25e or 28a-1 show any injury or other treumetic event, the Medical Example must be notified at ance.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	1	Was Decede If Yes, specif 1 ☐ Yes 25		Specify:	gin? (Spec i, Puerto Ri	ican, etc.)	0-	Black, White	, etc.		
215-0036	72 hou	ted	15. Decedent's Ed (Specify only highest gra	lucation	16a. Dece	dent's Usual	Occupat	tion	af warking		16b. Ki	nd of Business/I	ndustry		
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Bal	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licer	ean	H	2. Name and blloway	Fire	ral H	bine, P			en Ave.			
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	ding Pl n. After th funeral	ou:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day)	Year) 28b. Time of Injury		. Injury Work?			ld. Describe	how injur	y occurred			
Division	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		y - At home, farm, st (Specify)	M reet, factory,		es 2 l		f. Location (City or To			ral Route Number.		
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#24a, perVERB. G867, 574707, WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death HAFER, JR. Month ERNON JOSEPH 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deaf Allegany 23657 McMullen Highway Rawlings 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Month, Day, Jun 11, 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 M 2 □ F 1941 214-38-5329 Yrs. 65 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Allegany Rawlings 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23657 McMullen Highway 21557 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No ff Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Warehouse Westvaco Corp 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Vernon J. Hafer, Sr. Flora (Mort) Hafer Berzansky 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23657 McMullen Highway Rawlings MD 21557 19a. Informant's Name/Relationship (Type, Print) wife Kathy Hafer 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State **Duvall's Cemetery** 5/1/2007 PA Saxton 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensei 22. Name and Address of Facility al Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a Jarty Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastance (Fil Ca of 3 week Due to (or as a consequence of) Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetaf death 23d. Date of delivery 3 ☐ Ectopic pregnancy 4☐ Pregnant at time of death Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 🔼 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 2 ER/Outpatient 3 DOA 1 Inpatient 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation

Examiner igned by the attending physicien and be detached for use as the burial-transit The law requires that the death certificate be executed P.0. signed by Records, has certificete of Vital within 24 hours after death. To the Funeral Director; After this certific completely filled in by the funeral director, Attending Division To the Hospitel

Physician

/Medical

Examiner

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Baltimore, Maryland 21215-0036

fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> Completed 25. Was case referred to medical examiner? Be ဥ 1 Yes 2 No 27. Manner of Death Certification: 1 Natural 2 Accident 6 Could not be determined 3 Suicide 28e. Pface of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number

29d. Date signed (Month, Day, Year)

4205

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GREGG DONALDSON, M.D. 912 SETON DR. CUMBERLAND, MD

31. Date filed (Month, Day, Year)





State Registrar

December Name First, Model of Beath Company Comp				1- For State of Maryland / Department / Department / Department / Department / Department / Depa	artment of Health and M		2UU1	14535				
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

	•	For State Registrar		te or ivie	ar y larra		tificate o		ath		Reg. No.	007	1 1	535
Physicia	an	1. Decedent's Name (First, Middle	e, Last)							2. Date of Dea Month	Day	Year	3. Time of	
/Medic	_	Edna Ashby Hobl	os							April	11 14, 2007 1:			PM
Examin	er	4a. Facility Name (If not institution	_	nd number)				m, or Loc	cation of Death			ounty of Death		
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Funeral Director		5. Social Security Number 578-20-0248	6. Sex 1 ☐ M 2	-	e (In yrs. la:	Yrs.			Under 24 Hrs. lours Min.	8. Date of Birt (Month, Da May 14	v. Year)	Cour	lace (State o itry) inia	r Foreign
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any fulury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	1 ☐ Never Married 2 ☐ Marr 3 🖾 Widowed 4 ☐ Divorced	ied Arr	ned Forces?]Yes 2∭ 'es, Give ar or Dates:			f Yes, specify (nic Origin? (Spe Mexican, Puerto pecify:	Rićan, etc.)		Black, White, Specify: Whi		
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ng ph as t	Med	IF FEMALE:					-							
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely illied in by the funeral director, page 2 should be defached for use as the burial-transit	Physician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 £	res, outcome Live birth Pregnant a Unknown	2 Fetal	death 3	Ectopic pregn Other (specif				23	3d. Date of deliv Month		Year
es that gned b be deta	by Pł	Part II. Other significant conditi	ons contributi	ng to death b	ut not resul	ting in the u	nderlying caus	e given i	n Part I.		/	e contribute to t		
requir sen si rould	ted									1 🗗	Yes 2□	INO 3 Pro	bably 4 □l	JIKNOWN
The law I	Completed									24a. Was auto perfo 1∐ Yes		24b. Were auto prior to co death? 1 ☐ Yes	opsy findings impletion of c	available ause of
slan; ertific ctor,	Be (25. Was case referred to medica examiner?							6. Place of Deat	h (Check only o	one)			
hysic his co	은	1 ☐ Yes 2 ☑ No	Hospita	1 🔲 inpati		R/Outpatier					-	□Other (Speci	fy)	
ding P h. : After t funera		27. Manner of Death 1: Natural 5 Pendir 2 Accident investi	ng	a. Date of Inju (Month, Da		28b. Time o Injury								
a er dea l Director d n by the	Certification:	3 Suicide 6 Could 4 Homicide determ		e. Place of in building, e	ury - At hor tc. (Specify,	me, farm, sti	rm, street, factory, office 28f. Locati City o			28f. Location (City or To	ocation (Street and Number or Rural Route Number, ity or Town, State)			nber,
e Hospita 124 hours ie Funera ifetely fille	Medical C	29a. Certifier 1 Certifyin (Check only one) 2 Medical	Examiner: C	To the best in the basis o	of examinati	vledge, deat ion and/or ir	h occurred at to vestigation, in	he time, my opini	date and place, ion, death occur	and due to the red at the time	cause(s) a , date and	and manner as s place, and due	stated. to the cause(s	s)
To the within To the comp	Me	29b. Signature and title of certific	m	W	m	n	29c. Li	cense nu	umber 922	0	29d. Date	signed (Month,	Day, Year)	,
4	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)									08				
Sta Registi		31. Date filed (Month, Day, Year APR 19	2007	32 egist	rar's Signat	B 4	north							

			1 - State State of Maryland / Dep	artment of Health and Mertificate of Death	ental Hygie	211117	14537
			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physicia		Dor i s Virginia Johnson Hodges		April 17	Day 2007 Year	11:58 P ™
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			St. Mary's Hospital	Leonardtown		St. Mary'	S
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birth Cou	place (State or Foreign ntry)
	Director		577-34-4097 1 M 2 M P 80 Yrs. Usual Residence of Decedent		Oct. 27,	1926 Wash	place (State or Foreign ntry) nington DC
	tand		10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	Mary -1 • h	tor	Maryland St. Mary's Mechani	icsville			1 ☐ Yes 2 X No
	r 28s	Directo	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cou	intry?
	h witi	al D	40220 Beach Drive	20659		USA	1
	ems erms	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13.	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Ameri Black, White	
ð	within 72 hours after death with the Maryland ene then "natural", or items 23a or 28s-f ehow the Madical Examinar most be notified at		1 Never Married 2 Married 1 Yes 21 No	1 ☐ Yes 2 ♥☐ No Specify:		Specify:	White
215-0036	hours tural'	ed by	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education 16a. Dece	edent's Usual Occupation	100		and a second
Ċ	in 72	Completed	(Specify only highest grade completed) (Give	e kind of work done during most of workir DO NOT use retired)	ng lot	. Kind of Business/Ir	laustry
717	iene.	omp	Elementary/Secondary (0-12) [College (1-4or 5+)	nistrative Assistan		JS Governm	ent
ַ	illed Hygi other	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name		den Surname)	
land	Aenta Aenta rked tic ev	To E	Henry M. Johnson	Beulah	E. Shiple	ey .	
Mary	2 sho and h is ma	. 9	19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ing Address (Street and Number or Rura	l Route Number, Ci	ty or Town, State, Zi	o Code)
	s 1 and 3 f Heelth item 27 other tr	9		' All Faith Church			
ore ore	00		1 Di Burial 2 I I Cremation 3 I Hemoval from State	ematory or other place)		. Location - City or T	
Ē	Pages Iment of tant: If it tany or o		4 □Donation 5 □Other (Specify) MD Veter	rans' Cemetery 4-24	and the same of th		
Baltimore,	permit. Pag Depentment Important: I any injury o	3 3		2. Name and Address of Facility Lantt Funeral Home		l Washingt , MD 20601	
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	iter the mode of dying, such as cardiac or	r respiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Endoblism 3m			Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):	1			
	LXG/IIII/CI	_	Sequentially list conditions, b. Regulations	melony for	cancer		Tank
	ed isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	8			2 1
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09/8	centificate be executed ding physicien and use as the burial-transit	dical E	L _a				
200	ificate g phy as the	edlo	u.				
X R R	leath certific ettending pl	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 1□Live birth 2□Fetal death 3(☐Ectopic pregnancy		23d. Date of deliv	ery
	death	sicie	1 Yes 2 Ho	Other (specify)		Month	Day Year
r Ö	that the led by the detache	Phy	9 U Onknown		T	<u> </u>	
-	w requires that the de been signed by the c should be detached	þ	Part II. Other significant conditions contributing to death but not resulting in the t	underlying cause given in Part I.	23e. Did tobac	co use contribute to	
ecords	requires seen sign hould be	Completed			Tes	2 No 3 Pro	bably 4 □Unknown
္ခ	a se s	nple			24a. Was an autopsy	prior to co	opsy findings available empletion of cause of
VITAI H	icien: The certificate h rector, page				performed 1 ☐ Yes 2 █		2□ No
<u> </u>	Physicien: r this certifica ral director, p	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death			
ō	<u>a</u> = <u>e</u>	5	1 Impatient 2 En/Outpatie	ALL SEL DON 4 INdising Flori	ne 5 Residence 28d. Describe how i	e 6 ☐Other (Speci	fy)
0	tending leath. tor: After the funer	tlor	27. Manner of Death 1 □ Hatural 5 □ Pending 2 □ Accident investigation 28a. Date of Injury (Month, Day Year) Injury	of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No		.,,	
DIVISION	al or Attending after death. I Director: After d in by the fune	fica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st	treet, factory, office 2		t and Number or Rur	al Route Number,
É	i Diffe	Certification:	4 ☐ Homicide determined building, etc. (Specify)		City or Town, S	tate)	
	5 4 4 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, any estigation, in my opinion, death occurre	and due to the caused at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the within 2 To the Comple	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month,	Day, Year)
			Kush / Janpan	D.50111	2	1/17/20	77
3	B 12		30. Name and address of person who completed cause of death (Item 23a) (Type KRISHMA JMARAMAN, 28227 Three	Print) Dee Notch Road, Mech	anicsvil	le, MD 206	559
	Sta Registr		31. Date filed (Month, Day, Year) APR 2 0 2007 32. Registrar's Signature				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Anna Aydelotte Hudson April 2007 0530 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Atlantic General Hospital Berlin Worcester If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🔀 F 217-36-2462 98 Director Jan. 18. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or itsms 23e or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9209 Logtown Rd. 21811 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White څ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: If Item 27 is marked other the sny injury or other traumatic event, Insu 2002. Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Jacob Avdelotte Leah Ellen Timmons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Iris Phillips (daughter) 10457 Georgetown Rd., Berlin, Md. 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State 4-25-2007 | Berlin, Maryland Evergreen Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funda Service License 22. Name and Address of Facility The Burbage Funeral Home 108 William St., Berlin, Md. 21811 utal. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Preumonia Sequentially list conditions, a any, reading to annual accause. Enter Underlying Cause (Disease or injury that initiated events Dira to (or as a consequence or): resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ Mo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 2 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No withis 24 hours after death To the Funeral Director; , completely filled in by the f 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 053612 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 9733 Healthway Dr. Berlin, MD K. Barer MD 31. Date filed (Month, Day, Year) State APR 23 Registrar

Division or Vital Records, P.O. Box 68760. Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifice within 24 hours a

BA 10 Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year) APR 23 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

EHULAN WARIS

HOSPICE COASTAL 32. Registrar's Signature

29c. License number

D0058410

29d. Date signed (Month, Day, Year)

POBX # 1733 - SALISBURYUD. 21801

4-21-07

07-02944 Delena Head

with the Maryland

death v

after

21215-0036

Baltimore, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 11.54 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Time of Death Month Day April 17, 2007 **Medical Examiner** 0920 hrs DeLena Ruby Head 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Calvert Memorial Hospital Prince Frederick Calvert 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or Funeral Foreign Country) Wash, Months Days Hours Director 578-32-5896 1 M 2 X F 82 April 25 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Calvert Co. 28a-f show Lusby 1 Yes 2 X No notified at once. Director 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 11820 Sitting Bull Circle U.S.A. 20657 23а Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Yes If Yes, Give Year 3 X Widowed 4 Divorced Yes 2 X No specify: the Medical Examiner Specify: White other than "natural", ģ Pages 1 and 2 should be filed within 72 hours nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natur: or other traumatic event, the Medical Exami 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 6b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Ruby DeLena Burkhead 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4003 Adrienne Drive, Mary E. Pryor (Daughter) Alexandria, VA 22309 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, April 23 1 X Burial 2 Cremation 3 Removal from State crematory or other place) Cedar Hill Cemetery 2007 Suitland, Maryland 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 8125 Southern Maryland Blvd., Owings, MD 20736 the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician one cause on each line failure. List only Between Onset and /Medical Death a, Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): Examine if any, leading to immediate (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical UNPENDED AMENDED attending physician or use as the burial -IF FEMALE 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 V No 9 Unknown Unknown detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed peen 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? Yes 2 V No Nο 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Other: Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 Other: 1 Yes No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred

The law requires that the death certificate be executed Box 68760, Records, P.O. To the Hospital or Attending Physician: Division of Vital After this Certification:

within 24 hours after death.

To the Funeral Director: filled in by the completely

1 V Natural

Accident

Suicide

Homicide 29a. Certifier 1

2 1

29b. Signature and title of certifie

2

Medical

State Registrar

30. Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 31. Date filed (Month, Day,

200

gistrar's Signature

(Specify)

and manner stated.

Pending

Investigation

Could not be

28f. Location (Street and Number or Rural Route Number, City

April 18, 2007

29d. Date signed (Month, Day, Year)

or Town, State)

111 Penn Street, Baltimore, MD 21201

1 Yes 2 No

28e. Place of Injury - At home, farm, street, factory, office building, etc

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Bernice Hill April 19, 2007 1:31 A^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Clinton Prince George's Southern Maryland Hospital Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 X F 79 Director March 25, 1928 Maryland 213-24-2970 Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. tnside City Limits 10b. County rithen "netural", or iteme 23s or 28s-f show the Medical Examinar must be notified at 1 ☐ Yes 2X No MD Director Prince George's Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6009 Chris-Mar Avenue 20735 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-tf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 2 Married altimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: ģ 3 Widowed 4 □ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12College (1-4or 5+) marked other then Fiscal Accountant Federal Government permit. Pages 1 and 2 should be file Depertment of Heelth and Mental Hy, important: if item 27 is marked othe my injury or other traumatic event, gongs. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Paul D. Tayman Nora T. Lawson ۵ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Burgess (daughter) 20754 452 Jewell Court Dunkirk, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Apr 23 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State Washington National 4 ☐ Donation 5 ☐ Other (Specify) 2007 Suitland, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Lee Funeral Home Calvert, PA gary 3. Goff 8125 Southern Maryland Blvd. Owings, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ACUTE INTRACENEBLAI **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner signed by the ettending physicien and d be deteched for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2□ No 1 Yes 2 No Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospitat: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ۵ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this within 24 hours effer death.

To the Funeral Director: After the completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Division of Vital Records, P.O. Box 68760

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Line Center #207 Waldorf

and aderess of person who completed cause of death (Item 23a) (Type, Print)

2007

32. Registras Signature

Philip Wisotsky, MD 12070 01d

31. Date filed (Month, Day Year)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Ragistra Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2007 April 20, **Physician** Ann Bernice Hewitt 4:00 Αм /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Laurel Regional Hospital Laurel Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov 5, 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1919 1 ☐ M 2 🖔 F Months Days Hours Yrs. 578-36-9398 Director Washington, DC Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ir than "naturel", or items 23a or 28a-f ehow tre Medical Examinar must be notified at MD Howard Elkridge 1 ☐ Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 6391 Rowanberry Drive Apt 323 21075 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. e filed within 72 hours after call Hygiene.

other than "naturel", or item 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: δ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be s 1 and 2 should be fi f Health and Mental F Item 27 is marked of Howard P. Payne Bessie G. Chick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vicki Thore (daugh.-in-law) 9015 Cabin Court Owings, MD 20736 Peges 1. vent of Hear. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State permit. Pege Department of Important: If eny injury or once. Mt. Olivet Cemetery 4 ☐Donation 5 ☐ Other (Specify) 2007 Washington, DC 22. Name and Address of Facility 21. Signature of Tuneral Service Licensee Lee Funeral Home Calvert, PA Gary Goff 8125 Southern Maryland Blvd. 20736 Owings, MD Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Congestive Heart Failure **Physician** 1 Week disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ASCVD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examin ending physicien and use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760 Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 🛣 No Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the al 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No page 5 has autopsy performed? 1 ☐ Yes 2 No To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of fnjury (Month, Day Year) 28b. Time of Certification: 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 Pending death. 1 Yes 2 No 2 Accident efter death the within 24 hours efter de: To the Funeral Directo completely filled in by th 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D24721 April 20, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Syed Sadig, MD 14333 Laurel Bowie Road Laurel, MD 31. Date filed (Month, Day, Year)
APR 2 32. Registras Signature State 2007

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Selena May Holland Apr 17, 2007 11:35 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Port Republic Calvert 3030 Bicentenial Court If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 💢 F 213-44-2656 Maryland **Director** May 31, 1937 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show must be notified at MD Calvert Port Republic 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 3030 Bicentenial Court 20676 U.S.A. Pages 1 and 2 should be filed within 72 hours after death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 14. Race - American Indian 12. Was Decedent Ever in U.S. 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛭 If Yes, Give Year or Dates: 2 🗶 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black þ 3 ☐ Widowed 4 ☑ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nursing Home Nurse's Assistant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be n and Mental F Beatrice Jones Clarence Holland ပို 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dianne Sewell /Daughter 66 Central Village Drive Prince Frederick, MD 20678 f Health a 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or oth 1 Burial 2 □ Cremation 3 □ Removal from State 04/25/07 Chesapeake Beach, MD 4 ☐ Donation 5 ☐ Other (Specify) **Ernestine Jones Cemetery** 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sewell Funeral Home Glades 1451 Dares Beach Road Prince Frederick, MD 20678 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Garcinoma with Physician /Medical Due to (or as a consequence of) Examiner Nen Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) Division or Vital Records, P.O. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by IABE TES MELLITUS 2 No 3 Probably 4 Unknown 1 ☐ Yes PERTENSION Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 ☐ Yes မှ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Matural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No i Director: 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 1/2001

State

HOLP RD. Prince Frederica.

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

32. Registras Signature

anual mumhi m.D

Box 68760, P.O. Division or Vital Records,

within 2

State

one)

29b. Signatur

30. Name an

Registrar

and manner stated.

cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 16, Day 2007 Year Physician 1:30 Virginia Ellen Hensley /Medi Exami **Funeral**

Рм

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any finury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Director

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burtansit ompletely filled in by the funeral director, page 2 should be detached for use as the burtansit

Division or Vital Records, P.O. Box 68760,

Examin	er	4a. Facility Name (I	-					r Location of Death		4c. County		
N . W.		Anne Aru	ndel Med:	ical Cent	ter		Annapol			Anne		
uneral irector		5. Social Security N 218–24–6	405	Sex 1 □ M 24 □ F	'. Age (In yrs. k		If Under 1 Year Months Days	Hours Min. No	Date of Birth (Month, Day vember 3	, 1928	9. Birtl Mary	hplace (State or Foreign untry) Tand
>		Usual Residence of 10a. State	f Decedent 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits
f sho	ō	Maryland	Anne Arı	undel	Anna	polis						1 □ Yes 2 🖔 No
28a- notif	rec	10e. Street and Nur		under	IIIIIG	POLLO	10f. Zip Code		10	g. Citizen of	What Co	untry?
3a or st be	i Di	130 Hear	ne Road	Apt. 202	2		214	01		USA		
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status	ried 2□ Married	12. Was Deced Armed Ford 1 Tes 2 If Yes, Give Year or Dat	lent Ever in U.Sces? 2[X]No		Vas Decedent of H f Yes, specify Cub I ☐ Yes 2 No	lispanic Origin? (Specifi an, Mexican, Puerto Rid Specify:	y Yes or No- can, etc.)		ck, White	rican Indian, e, etc. ite
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27 Is mar r traumat	_	19a. Informant's Na Diane Mor		,				and Number or Rural F redericksb		•		Zip Code)
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Importa any inji		21. Signature of	Lice	nsee		GE 29	Name and Address orge P. 1973 Solom	Kalas Funer ons Island	cal Hom	e, P.A Edgewa	ter,	MD 21037
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To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	! months? □ No		th 2 ☐ Fetal int at time of de	death 3	Ectopic pregnanc Other <i>(specify)</i>	у			ate of deli onth	ivery Day Year
n signed by uld be deta	by	Part II. Other signit	ficant conditions	contributing to dea	ath but not resu	lting in the u	nderlying cause giv	en in Part I.	23e. Did toba		1	the cause of death? obably 4 □Unknown
ate has bee page 2 sho	Completed					_			24a. Was an autopsy perform 1 Yes 2	ed2		atopsy findings available completion of cause of
ertific ector,	Be (25. Was case refer examiner?	r"	Hoorital	0		I a	26. Place of Death (C	Check only one)		
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or: After the funer	ation:	27. Manner of Deat Valural 2 Accident	tn 5 □ Pending investigatio 6 □ Could not b	n .	ı, Day Year)	28b. Time of Injury		Yes 2 □ No	d. Describe how			
ral Direct lled in by	Certification:	3 ☐ Suicide 4 ☐ Homicide	determined	building	g, etc. (Specify	·)	eet, factory, office	l.	City or Town,	State)		ıral Route Number,
the Fune npletely fil	Medical	29a. Certifier (Check only one) 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner of examination and/or investigation, in my opinion, death occurred at the time, date and place, and manner stated.									, and due	to the cause(s)
To	2	29b. Signature and	fittle of certifier	01	·		29c. Licens	5 4 9 Y	29	d. Date signe	120	h, Day, Year)
		30. Name and add	ber	Kesni	de	1	Print)	An well	Med	ical	Co	ited
Sta Registr		31. Date filed (Mon	APR 1 8	2007 32. Re	strar's Signat	#	hout ,					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 01:50 AM Robert Douglas Johnson 25 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BAYVEEN MEVIGAL CENTER BALTEMORE HOPKINS If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days NSaralina 244-88-0507 November 30, 1951 10a. State 10c, City, Town or Location 10b. County 10d. Inside City Limits X Yes 2 No Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21205 U.S.A. 907 North Chester Street 12. Was Decedent Ever in U.S. Armed Forces? TO Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 🏖 ☐ No Specify: Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Painter Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Cathrine Odssa Ernest Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 403QueensWoodBlvd., ElizabethCity, North Cassandra Jones/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) NewOakgroveCemetery 4/30/07 ElizabethCity, N.C. 21. Signature of Funeral Service Licenses Marzullo Funeral Chapel, P.A. 6009HarfordRoad, Baltimore, Maryland21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respiratory 48 hours disease or condition resulting in death) Due to (or as a consequence of): Respiratory 72 hours Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CP53 Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? to Agent orange, atomized puints, 1 Yes 2 No 3 Probably 4 Unknown subacute embolic infarcts 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28d. Describe how injury occurred

Physician /Medical Examiner and burial-trar nding physician the ası

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After

To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral

Physician

/Medical

Examiner

Funeral

Director

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permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 3 any injury or other traumatic event, the Medical Examiner mu, once.

Baltimore, Maryland 21215-0036

Box 68760.

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Completed

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Examiner Physician/Medical 2 Completed Be ဥ

Certification:

Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown

cerebellum and cortex Tricuspid

27. Manner of Death 1 Natural 2 Accident

5 ☐ Pending investigation 6 Could not be determined 3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 □ Yes 2 □ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

BALTIMORE

(Check only one)

Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifie:

29c. License number

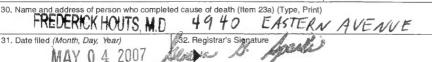
25, 2007

29d. Date signed (Month, Day, Year)

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State Registrar 31. Date filed (Month, Day, Year)

MAY 0 4 2007



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 18 2007 Suzanne Judge April 06:30A M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 605 Beach Drive Annapolis Anne Arundel 8. Date of Birth (Month, Day, Year) 06/16/1912 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign Days 1 □ M 2 □ F Hours Illinois 577-50-4580 94 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 □Yes 2XNo Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 605 Beach Drive 21403 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 💆 No White Specify: 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Dept. of Interior Elementary/Secondary (0-12) College (1-4or 5+) Accountant Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Llewellen Foulke Leila Craig 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline Biess/Daughter 523 Tayman Drive, Annapolis, Maryland 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 04/20/2007 Davidsonville, Maryland 4 Donation 5 Other (Specify) Lakemont Memorial Gardens 21. Signatu Funeral Service Licerus 22. Name and Address of Facility George P. Kalas Funeral Home Nater <u> 2973 Solomons Island Rd.,Edgewater, MD 21037</u> 23a. Party Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) VQ S Due to (or as a co equence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of de ?? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 nknown

Physician /Medical **Examiner** Examine

Physician

/Medical

Examiner

Funeral

Director

a or 28a-f show be notified at

r than "natural", or items 23a the Medical Examiner must b

within 72 hours after death

Hygiene.

permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Important: If Item 27 is marked other the any Injury or other trainmant.

Baltimore, Maryland 21215-0036

Director

Funeral

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The law requires that the death certificate be executed and burial-trai physician the attending plant of the sas the detached ģ peen has page 2 certificate Hospital or Attending Physician: After

Division or Vital Records, P.O. Box 68760

Physician/Medical Completed Be ို Certification: after death Director: / in 24 hours the Funeral Dire Medical

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25	. Was case refer	red to medical						26.	Place of Deat	h (Check only	one)			
	examiner?	No	Hospital:	1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Hon							sidence 6	☐Other (Spe	cify)	
27	Man r of Death 1	h 5 ∏Pending investigation	(Date of Injury (Month, Day Year)	28b. Time of Injury	М	1	Injury at Work? 1 ☐ Yes	2□No	28d. Describe	how injury	occurred		
	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)				nber,	
29	a. Certifier (Check only	1 Certifying Ph 2 Medical Exam	niner: On t	to the best of my know	owledge, death ation and/or inve	occurre	ed at tl on, in	he time, da my opinior	ite and place, n, death occur	and due to the	e cause(s) : e, date and	and manner as place, and due	stated. to the cause(s)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Dav. Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PEI 601 PC

31. Date filed (Month, Day, Year) State APR 1 8 2007 Registrar

2. Registrar's Signature

20

within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

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Registrar DHMH 17 Rev 1/2001

State

person who completed cause of death (ITem 23a) (Type, Print)

M WILLIAMS, D.O. MONTGOMERY HOSPICE 6001 MUNCASTER MILL RD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signa

31. Date filed (Month, Day, Year APR 2 3 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dorothy Lucille Garrison Knebel 4/16/2007 1940p₩ 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapol**i**s 8. Date of Birth (Month, Day, Year) 10/14/1917 If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2X F NewJersey 89 077-07-6407 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No MD Anne Arundel Annapolis 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2707 Riva Rd. 21401 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 → No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 21 No Specify: White Specify: 3 ☐ Widowed XX Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Minister Christ Church Unity 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Eugene Garrison Lovina McMurray 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary Knebel Son 6548 Shady Side Rd. Shady Side, MD 20764 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial XXCremation 3 ☐ Removal from State Metro Crematory 4/18/2007 4 □ Donation 5 □ Other (Specify) Baltimore, MD 21. Signature of Suneral Service License 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 Vat 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RESTLICTIVE disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 200 No 1 🗀 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy perform

Physician /Medical Examiner

burial-transit

the use as

for

s been signed by the should be detached

page 2

certificate l

this funeral

After or Attending

within 24 hours after death To the Funeral Director: filled in by the

Hospital

the

A

Completed

Be

Certification:

physician

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760.

Department of H
Important: If Itel
any injury or oth

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

ns 23a or 3 must be r

of Health and Mental Hygiene.
Item 27 Is marked other than "natural", or items other traumatic event, the Medical Examiner mi

Pages 1 and 2 should be filed within 72 hours after

Maryland 21215-0036

altimore,

Director

Funeral

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Completed

Be

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with the Maryland

Examine Physician/Medical

> 1∐ Yes 26. Place of Death (Check only one)

25. Was case referred to medical examiner? \$ XN0 1 ☐ Yes 27. Manner of Death

1 Inpatient 28a. Date of Injury (Month, Day Year) 5 Pending investigation

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 ER/Outpatient 3 DOA 28b. Time of Injury

Injury at Work?

1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Avatural 2 Accident

3 ☐ Suicide

4 Homicide

Douglas

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

6 ☐ Could not be determined

D39037

4-17-07

State Registrar

31. Date filed (Month, Day, Year) 2007 **APR 19**

Arkey Arrap. WI 32. Refistrar's Signature

2001 medica

DHMH 17 Rev 1/2001

State of Maryland	Department of Health	and Mental Hygiene

			For State		State	of Maryl		artment of H <i>rtificate of L</i>				A 10 10	. 1
	, ,		Registrar 1. Decedent's Nan	ne (First, Midd	e, Last)		001	tineate of L	Jean	2. Date of De	Reg. No.	U 0 /	3. Time of Death
	Physicia /Medic		CHARLOTTE	L.	KAREL					Month APRIL 1	Day 9. 2007	Year	8:53 A ^M
	Examin		4a. Facility Name ((If not institutio	n, give street and nu	ımber)		4b. City, Town, or	Location of Death			ity of Death	10.55 N
			SPRING HOUS					BETHESDA				TGOMER	Υ
	Funeral		5. Social Security I		6. Sex 1 ☐ M 2 🕱 F		yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	ıy, Year)	Coui	
elio le	Director	i.	218-14-74 Usual Residence of			85	115.			May 28,	1921	Ma	ryland
	ow ow		10a. State	10b. County	'	10c.	City, Town or Lo	cation				1	I 0d. Inside City Limits
	Mary Firsh filed	to	Maryland	Mont	gomery			Bethes	da				1 ☐ Yes 2 K No
	or 28g	Director	10e. Street and Nu	umber				10f. Zip Code			10g. Citizen o	f What Cour	ntry?
	23a c		4925	Battery	Lane, Apt	306		2081	.4			U.S.	Α.
	illed within 72 hours after death with the Maryland Hygiene. Hydiene. Then 1990 or 28a-f show ther the Medical Examiner must be notified at	Funeral	11. Marital Status		Armed F		n U.S. 13. \	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (S n, Mexican, Puert	pecify Yes or No o Rican, etc.)	14. R	ace - Americ ack, White,	
9	s affe	by F	1 ☐ Never Mar 3 🗷 Widowed		If Yes, G	2 No		1 ☐ Yes 2 🗷 No	Specify:		Spec	oify:	
3	hour tural		3 A Widowed		Year or I	Jales.	16a. Decer	dent's Usual Occupa	ation		16b. Kind of		ite
2	iin 72 iin 72 iin "ina Medic	Completed	(Spe	ecify only highe	st grade completed,		(Give	kind of work done o	luring most of wor)	king			adday
7 7	giene giene rr tha	E	Elementary/Sec	ondary (0-12)	College 4	(1-4or 5+)	Res	earch Grant	s Analyst		Nationa	1 Insti	tutes of Healt
2	al Hy l othe	Be	17. Father's Name	(First, Middle,	Last)				18. Mother's Nan	ne (First, Middle	, Maiden Surna	ame)	
2	ould by Ment arked	2	Charle	es Solomo	n Harold Lo	ckman			Sadie	Durst			
<u> </u>	2 should be filed within and Mental Hygiene. Is marked other than raumatic event, the Me		19a. Informant's N	Name/Relations	ship (Type. Print)		19b. Mailin	ng Address (Street a	and Number or Ru	ıral Route Numb	er, City or Tow	n, State, Zip	Code)
בי טֿ	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. If Health and Mental Hygiene feen frem 23a or 28a-f show flem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Richard 20a. Method of Dis	Karel -	Son	lan	1708 b. Place of Dispo	E. Fort Ave	nue, Balti	more, Mar	yland 21 20c. Location		Chaha
2	0 0 4 1		1 🗶 Burial 2	Cremation	3 □Removal from	State	King David	natory or other plac				-	
-	C 40 -3		4 ☐ Donation 21. Signature of F	5 Other (S			Memorial 22	Gardens . Name and Addres)/2007	Falls C	hurch,	Virginia
2	permit, Depart Import any inj once	0 9) am	and		ewig		ines-Rinald	i Funeral	Home, Inc	ver Spri	ng. Mar	yland 20904
Н	- 491 Os		23a. Part1. Enter	the disease, o	r complications that t only one cause on	caused the							Approximate Interval Between
F	hysician	1	Immediate Cause disease or condition	(Final			a of the G	all Bladder	- Metasta	tic			Onset and Death
	/Medical		resulting in death))			sequence of):		110 000 00				
	Examiner	L	Sequentially list or	onditions,	b								
	led 1sit	nine	Sequentially list or if any, leading to it cause. Litter Und Cause (Disease or	mmediate lerfyling → r iniurv	Due to	(or as a con	sequence of):						
	al-trai	Examiner	that initiated event resulting in death)	ts .	c	(or as a con	sequence of):	<u></u>					
3.	incate be executed physician and is the burial-transit	edical			d.								
	= 0.8												
5	eath certifi attending for use as	sician/M	IF FEMALE: 23b. Was deceder		23c. If yes, ou	utcome pf pre		lEctopic pregnancy				Date of delive	*
	e dea he att led fo	sici	in the past 12 1 ☐ Yes 2 9 ☐ Unknow	X No		nant at time		Other (specify)				Month	Day Year
	nat the de d by the a letached	Phy			ons contributing to	hoath but not	reculting in the ur	adortvina sausa give	on in Port I	220 Did t	obacco uso co	ntributo to t	he cause of death?
,	I he law requires that the death cert ate has been signed by the attending bage 2 should be detached for use a	by	Strok			yperten		idenying cause give	militratti.				pably 4 Unknown
2	w require been si should b	etec				ypercen	DIOI.						
	I ne lav ate has page 2 s	Completed	Нурет	clipidemi	.a					24a. Was auto		prior to co death?	ppsy findings available mpletion of cause of
			Atria 25. Was case refe	1 Fibril					00 Plans of Page	1□ Yes	2 K No	1 ☐ Yes	2□ No
-	rnysician: r this certific ral director,	o Be	examiner?		Hospital:	Inpatient :	2 ☐ ER/Outpatien	t 3 DOA Othe	26. Place of Dea			Ass	isted Living
5	Attending Proystclan: r death. ector: After this certific. by the funeral director,	Ë	27. Manner of Dea		28a. Date		28b. Time of		at	28d. Describe			y /
2	ath. or: After he funer	atio	1 🖪 Natural 2 🔲 Accident	5 Pendir investi	gation	nun, Day 10a	injury		res 2 □ No				
A .	or Atte	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could detern	pined 200. Flat	e of injury - A ting, etc. (Sp	At home, farm, streecify)	eet, factory, office		28f. Location (S City or Tox		nber or Rura	al Route Number,
ב ב	lo the Hospital of Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi		00- 0-45	4 197 0	Db. 11	- hack -'	les evuls de la company						
	# Hospital 24 hours a Funeral etely filled	edical	29a. Certifier (Check only one)	2 Medical	ng Physician: To the Examiner: On the and mai	e best of my basis of exan nner stated.	knowledge, death nination and/or in	occurred at the tin vestigation, in my o	ne, date and place pinion, death occu	e, and due to the irred at the time,	cause(s) and i date and place	manner as s e, and due to	tated. o the cause(s)
4	vithin 2	Me	29b. Signature and	d title of certifie	n/2011			29c. License	number		29d. Date sigr	ned (Month,	Day, Year)
,	10		111	ue/	All				H45839		April	19, 200	07
	10		30. Name and add	ires of person	who completed cau	se of death (Item 23a) (Type, I	Print)			F	,	
					5411 WEST C			202A, BETHE	SDA, MARYI	AND 20814			
	Sta		31. Date filed (Mon	nth, Day, Year, PR 20		egistrar's S	ignature	0.00					
	Registr	वा	н	II II G U	COOK A	WELLE J	15 600						

DHMH 17 Rev 1/2001

			for State Registrar	State of	Maryland /		artment of H		and M		0.0	107	11,553
	Q.		Decedent's Name (First, Middle	e, Last)		001	imouto or E	Journ		2. Date of Deat	eg. No. 🔼 🙏 h	1.3.1	3. Time of Death
3.75	hysici		Donald Rav	gene Ko	goc					Month April	Day 18	Year 2007	12:30 P ^M
	/Medio Examin		4a. Facility Name (If not institutio				4b. City, Town, or	Location o		.ipr.r.r		ty of Death	12:30 P
			Calvert County	Nursing Ce	enter		Prince	Frede	eric	ς	Ca]	lvert	
	ineral rector		5. Social Security Number 219–18–1748	6. Sex 7 1 X M 2 □ F	'. Age (In yrs. last 85	t <i>birthd</i> ay) Yrs.	If Under 1 Year Months Days	If Under a	24 Hrs. Min.	8. Date of Birth (Month, Day, Aug. 19	Year) 1921	9. Birthp Coun Nebr	lace (State or Foreign htry)
ъ	min minimizações		Usual Residence of Decedent							Aug. 17	1221	IVEDI	aska
ırylan	t at	3	10a. State 10b. County		10c. City, To	own or Lo	cation					1	0d. Inside City Limits
e M	8a-f s	Director		Arundel	Ros	se Ha							1 ☐ Yes 2 No
with th	a or 2 be no		10e. Street and Number				10f. Zip Code			10	og. Citizen of		
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036	al", ol Exam	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dat		1	I□Yes 2□XNo	Specify:			Speci	ty: Wh:	ite
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Ind 21215-0036 be filed within 72 hours after death with the Maryland tra Hygiene.	nd other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		12 17. Father's Name (<i>First, Middle</i> ,	/act)		busi	ness owne		de Nieres				service
Maryland 21215-0036 d 2 should be filed within 72 hours af th and Mental Hygiene.	ed of	Be c	Albert L	,	_					(First, Middle, N		,	
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and 2 sealth ar	27 is r trau		Lucy G. Koop,	, , , ,	1		Charlest				-		20714
S 1 a	item othe	2	20a. Method of Disposition		come	e of Dispos	sition (Name of natory or other place	i			20c. Location		
Page Page	int: If		1 ☐ Burial 2 X Cremation 4 ☐ Donation 5 ☐ Other (S		iaie i		tan Crema	1 :	04-	24-07 <i>I</i>	Alexano	dria.	VA
Baltimore, permit. Pages 1 ar Department of Hea	Important: If item 27 any Injury or other tr once.		21, Signature of Funeral Service	Licensee		22	. Name and Address	s of Facility	у				
<u> </u>	⊆ 76 O	-	1 real	1 de			usch Fune			_	Owings	s, MD	
100	£77) V	23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cau only one cause on eac	used the death. D ch line.								Approximate Interval Between Onset and Death
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isty.	<u> jar</u>	er	Sequentially list conditions,	b. Que to (or	r as a consequent	de of):							3 weeks
uted	ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events										
O,	an an rial-tr	Exa	resulting in death) Last	Due to (or	r as a consequenc	ce of):						-+	
ords, P.O. Box 68/60, requires that the death certificate be executed	pnysician and s the burial-transit	dical		d									
	ing pr	Med	IF FEMALE:								1		
Box Bath cert	attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birt	ome pf pregnancy th 2 DFetal dea	ath 3 🗆	Ectopic pregnancy					ate of delive onth	ry Day Year
D at t	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnai 9⊡Unknow	nt at time of death vn	າ 5⊡	Other (specify)					OHUI	Day real
that th	detac		Part II. Other significant condition	ons contributing to dea	th but not resulting	g in the un	derlying cause giver	n in Part I.		23e, Did tob	acco use con	tribute to th	e cause of death?
ecords,	should be detached	d by								1 □ Ye		3 ☐ Proba	
2 5 ()	shou	lete		******						24a. Was an	24h	Were autor	osy findings available
The law	certificate nas	Completed								autopsy	ed?/	prior to con death?	npletion of cause of
	director, page	Be C	25. Was case referred to medica	1				26. Place	of Death	1 Yes 2 (Check only one	No	1 ☐ Yes	2 □ No
L × .9	2 5	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 Inp	patient 2 ☐ ER/6	Outpatient	Othor			e 5 ☐ Resider		her (Specify	·)
n Or ng Phy	neral		27. Manner of Death 1 Natural 5 ☐ Pendin	28a. Date of (Month,	Injury 28t Day Year)	b. Time of Injury	28c. Injury Work?	at ?		8d. Describe how			<u>, </u>
SIO tendi eath.	the fu	Satic	2 Accident investig	gation			M 1 □ Y	es 2□N	10				
DIVISION or Attending after death. Director: After	in by	Certification:	3 ☐ Suicide 6 ☐ Could i 4 ☐ Homicide determ	inod Zoe, Place o	f injury - At home, g, etc. <i>(Specify)</i>	, farm, stre	et, factory, office		2	Bf. Location (Str. City or Town,	eet and Numi State)	ber or Rural	Route Number,
Dital urs a	ed		200 Cartifier 1 Cartifuin	a Physician: To the h	act of my knowled	dan daath	acquired at the time	n dat		-1			
	D :=	65	29a. Certifier 17 Certifyin	g Physician: To the b Examiner: On the bas	is of examination	and/or inv	estigation, in my opi	e, date and inion, deat	piace, a th occurre	nd due to the ca d at the time, da	use(s) and m te and place,	anner as stand due to	ated. the cause(s)
e Hosp 24 ho	e rune letely fi	9	one)	and manne	i Stateu.								
To the Hosp within 24 ho	completely fi	Medical	29b. Signature and title of certifie	and manne	i stated.		29c. License	number		29	d. Date signe	ed (Month, L	Day, Year)
To the Hospital or Attending Ph within 24 hours after death.	completely fi	Medica	29b. Signature and title of certifie	and manne	r stated.			_	9	29			Day, Year)
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To the Host within 24 host To the Europe	completely fi		29b. Signature and title of certifie 30. Name and address of person 37. Zahir Yousaf	who completed cause	of death (Item 23a	a) (Type, F	Print) Doo2	2718				ed (Month, L	Day, Year)
5	Sta	te	29b. Signature and title of certifie 30. Name and address of person	who completed cause 2417 Solom	of death (Item 23a	a) (Type, F und R	Print) Doo2	2718				ed (Month, L	Day, Year)

			Please I	State of Marylar					•		-	
			1 - For State Registrar	State of Marylar	-		e of Deati			giene Reg. No.	7 11 11	7 1455
			Decedent's Name (First, Middle, Last)						2. Date of Dea	ith		3. Time of Death
	Physici /Medi		GEORGE T. LO	ONG					APRIL	2 9		3:35 P M
}	Examir		4a. Facility Name (If not institution, give s	street and number)		4b. City,	Town, or Location	n of Death	-	4c.	County of Deat	
			285 N. Bohemia	Ave.			cilton				Cecil	
	Funeral Director		219-16-8041	7. Age (In yrs. 83	. last birthday) Yrs.	If Under Months		er 24 Hrs. Min.	8. Date of Birtl (Month, Day Feb 2	, Year)	9. Birt 924 Ma	hplace (State or Foreign untry) ryland
land	A 11		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ity, Town or Lo	ocation						10d. Inside City Limits
the Man	28a-f eh	Director	MD Cecil 10e. Street and Number	Ce	ecilto	on 10f. Zip	Code			10a Citi	zen of What Co	1 ☑ Yes 2 ☐ No
with	3a or		285 N. Bohemia	Ave.			913				S.A.	unity.
death	me 2	Funeral		12. Was Decedent Ever in U	J.S. 13.		dent of Hispanic C city Cuban, Mexic	Origin? (Spe	ecify Yes or No-		14. Race - Ame	
Maryland 21215-0036 Id 2 should be filed within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Important: if iteme 23a or 28a-f show important: if item 27 is marked other then "naturel", or iteme 23a or 28a-f show yor injury or other traumatic event, the Madical Examinat must be notified at once.	þ	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		lf Yes, spe 1 ☐ Yes			Hican, etc.)		Specify: White	hite
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∑ bud	d Mer nark natic	ဥ	George W. Long		10h Maili				ailey	- Cin	- Town Chata	Tin Condo
Mal d2si	th and 7 is r		19a. Informant's Name/Relationship (Ty)			•	(Street and Num					
a _ e	Health Iem 27 I		Carol Long (da 20a. Method of Disposition	aughter)	Place of Dispo	sition /Na	ne of		lton,		cation - City or	
Pages	t: H it		1 Burial 2 □ Cremation 3 □R 4 □ Donation 5 □ Other (Specify)	emoval from State	cometery, crei			5/2	/07		cilton	
Baltimore, permit. Pages 1 ar	artme ortan injur		21. Significant of Funeral Service License									•
m ž	Depa Impo eny i		*	MOO	510 G	alena 18 Wa	a Funer est Cro	al H	ome of t. Gal	St	ephen MD	L. Schaeck
	ysician		23a Part I Enter the disease, or compliance, or healt failure. List only or Immediate Cause (Final disease or condition	cations that caused the dea ne cause on each line.		ter the mod	de of dying, such a					Approximate Interval Between Onset and Death I 7 mon Ku
	Medical caminer		resulting in death)	Due to (or as a consec								
	3	7	Sequentially list conditions,	Due to or as a cons	mence of							
, g	nsit	ulu u	Sequentially list conditions, if any loading to many cause. Enter Undertying Cause (Disease or injury	Due to to as a conse	guerroe org							
60, C	n and al-tra	Examiner	that initiated events resulting in death) Last	Due to (or as a consec	quence of):			_				
- 0	ysician and e burial-transit	ca		l								
tificat	as th	ledi	/									
BOX	attending physi	an/N	230. Was decedent pregnant	3c. If yes, outcome of pregn 1□Live birth 2□Feta		∃Ectopic p	regnancy			1	23d. Date of del	
o dea	by the at tached fo	Physician/Medi	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of o		Other (sp					Month	Day Year
P.O.	d by Jetach	F.	Part II. Other significant conditions con	stributing to death but not re-	culting in the u	nderhing	auca gwan in Par	+1	23a Did to	hacco ii	se contribute to	the cause of death?
Hecords, P.O. Box 68 The law requires that the death certifical	signed b	2	Tarri, Still significant conditions to	imbaling to double but not re-	saming in the c	nderlying c	ausa givan in rai	(1 ,		_		obably 4 Unknown
CO N	should should	Completed							24a. Was	30	24b. Were au	topsy findings available
E E	page 2	ᇤ							autop perfor	sy med?/	prior to death?	completion of cause of
	certificate rector, pag	BeC	25. Was case referred to medical				26 Pla	ce of Death	1 Yes	2.2 No	1 🗆 Yes	2110
yaici Z	O to	ToB	examiner? 1 🗆 Yes 2 🔁 No	lospital: 1 Inpatient 2	ER/Outpatier	nt 3 DC			me 5 Resid		5 □Other (Spe	cify)
VISION Of VITA Attending Physician:	After thi funeral		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o		28c. Injury at Work?		28d. Describe h			
ig ig	death. ctor: Af y the fur	atic	1 Natural 5 Pending 2 Accident investigation			М	1 ☐ Yes 2 [□No				
DIVISION Of VITAL RECORDS, at or Attending Physician: The law requires to	after deatl Director: d in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, str ify)	reet, factor	y, office		28f. Location (S City or Tow	treet an n. State	d Number or Ru)	iral Route Number,
DIN To the Hospital or	within 24 hours after deatl To the Funerel Director: completely filled in by the	edical	29a. Certifier 1 Certifying Phys (Check only one)	sician: To the best of my knowner: On the basis of examination and manner stated.	owledge, deat ation and/or in	h occurred vestigation	at the time, date a	and place, eath occurr	and due to the ded at the time, d	ause(s) late and	and manner as place, and due	stated. to the cause(s)
o th	vithin Fo th sompl	Me	29b. Signature and title of certifier			290	c. License numbe	r		29d. Dat	e signed (Monti	n, Day, Year)
) [> P 0		1 MARCIO	hum n	1.0	0	00357	79	0	tpr	il 30.	2007
			30. Name and address of person who co	mpleted cause of death (Ite	m 23a) (Type,			. (/	/	,
	10		W. Bruce Obens				ohemia	Ave.	Cecil	tor	MD.	21913
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sign		4.						
	Registi	ar	編AY 0 4 2007	Madre 1	Local	Carlo						

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Vear **Physician** 11:50^A APRIL 2007 GAYLORD ORION LANDON 16 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL MEDICAL CENTER ANNE ARUNDEL ANNAPOLIS Age (In yrs. last birthday)

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1.**X**M 2□ F 84 Director NOVEMBER 11,1922 WISCONSIN 536-05-6404 Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County show 10d. Inside City Limits r 28a-f show notified at Director 1 TYes 2 No MARYLAND ANNE ARUNDEL ANNAPOLIS with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 3 iner must be n death v 2574 RIVA ROAD #20A 21401 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status "natural", or item nours after 1 X Yes 2 □ No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify þ Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 72 within Elementary/Secondary (0-12) College (1-4or 5+) the 12 1 and 2 should be filed wi Health and Mental Hygier om 27 is marked other th PRINTER PRINTING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be P CLARENCE LOUIS LANDON JEANETTE DUPRE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health of Important: if item 27 is any injury or other tra SHIRLEY LANDON VINING/DAUGHTER 497 POWELL DRIVE, ANNAPOLIS, MARYLAND 21401 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition APRIL 18. 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) CHESAPEAKE CREMATION 2007 STEVENSVILLE, MARYLAND 21. Signature of Funeral Service Licensee CREMATION AND FUNERAL CARE Will E Bourn M00672 814 BESTGATE ROAD, ANNAPOLIS, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) leac **Physician** Drust /Medical Due to (or as a consequence of): Examiner RSCAD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the death certificate be executed burial-trar Due to (or as a consequence of): Box 68760 physician Physician/Medical the as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 4□Pregnant at time of death 5 Other (specify) signed by the a P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has b autopsy performed? certificate 1□ Yes 2 1 No 25. Was case referred to medical funeral director Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 5 Pending investigation 1 Natural Injury within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 20373 4/17/07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2001 PARKWAY lobe. 31. Date filed (Month, Day, Year) strar's Signature State **APR 19** 2007 Registrar

DHMH 17 Rev 1/2001

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

	1 - State Registrar			•		artment of F rtificate of			Reg. No.		
ın al	1. Decedent's Name <i>(F</i> Willi		st) Linton					2. Date of De	Day 200	3. Time of Death 10:05 P	
ai er	4a. Facility Name (If no Shady G		e street and numbe lventist l		a1	Rock	r Location of Death ville		4c. County of Monts	Death gomery	
	5. Social Security Number 211–28–943	9 1	Gex 7.7	Age (In yrs. I	ast birthday Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da Aug • I	0,1937	9. Birthplace (State or Forei Country) PA	
tor		cedent b. County Montgon	nery	10c. City	, Town or L	ocation Gaithers	burg			10d. Inside City Limi 1 TXYes 2 ☐ N	
Funeral Director	10e. Street and Number		Court	.		10f. Zip Code	20879		10g. Citizen of Wh	at Country?	
by	11. Marital Status 1 ☐ Never Married 3 ☐ Widowed 4 ☐		12. Was Deceder Armed Force 1 X Yes 2 [If Yes, Give Year or Dates	s?] No 1.0.6.2		Was Decedent of HIf Yes, specify Cub. 1 ☐ Yes 2 【XNO		pecify Yes or No Rican, etc.)	14. Race - Black, Specify:	American Indian, White, etc. White	
Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Golf Pro 16b. Kind of Business (Give kind of work done during most of working life. DO NOT use retired) Golf Pro Golf										
To Be Co	17. Father's Name (First, Middle, Last) William J. Linton 18. Mother's Name (First, Middle, Maiden Surname) Elaine McFadden										
	19a. Informant's Name Audrey S.					ing Address (Street				* * *	
	20a. Method of Disposi 1 ☐ Burial 2 💢 4 ☐ Donation 5 [remation 3 □	Removal from Sta		emetery cre	osition (Name of ematory or other place itan ematory	Apri 200	Date 1 17 7	20c. Location - C	ity or Town, State	
	21. Signature of Funer	ral Service Licer			2	22. Name and Addre Deer Park				ne, 10 East 20877	
	23a. Part1. Enter the shock, or heart fa Immediate Cause (Fin disease or condition resulting in death)	ailure. List only	one cause on each	line. de	mer	nter the mode of dyin	ng, such as cardiad	or respiratory a	rrest,	Approximate Interval Between Onset and Death	
ical Examiner	Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Final line with Cause (Disease or influry that initiated events resulting in death) Last Due to (or as a consequence of): Cause (Disease or influry that initiated events resulting in death) Last Due to (or as a consequence of):										
Physician/Medical	IF FEMALE: 23b. Was decedent pr in the past 12 mo 1 ☐ Yes 2 ☐ N	nths?	23c. If yes, outcor 1 □ Live birth 4 □ Pregnant 9 □ Unknowr	2 □ Feta at time of d	l death 3	□Ectopic pregnanc	у		23d. Date Mont		

Phy /M Exa

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and

completely filled in by the funeral director, page 2 should be de

Division or Vital Records, P.O. Box 68760,

þ

Completed

Be

Certification: To

Medical

State

Registrar

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy performed

24b. Were autopsy findings available prior to completion of cause of death?

1∐ Yes 2 No 26. Place of Death (Check only one)

2 ☐ No 1 ☐ Yes

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

25. Was case referred to medical examiner? 2 No 1 🗌 Yes

27. Mann of Death 1 Natural

2 Accident

3 ☐ Suicide

4 Homicide

5 ☐ Pending investigation 6 Could not be determined

1 Inpatient 2 🗌 ER/Outpatient 28a. Date of Injury (Month, Day Year)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

3□ DOA 28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29a. Certifier (Check only one) 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person

31. Date filed (Month, Day, Year) APR 2 0 2007

on who completed cause of death (Item 23a) (Type, egistrar's Signature

			1- State of Maryland / Dep Registrar Ce	artment of Heartificate of De		, 0	ene g. No. 2 () ()	7 1455
ŀ	Physici	an	1. Decedent's Name (First, Middle, Last) Robert Glenn Langley			2. Date of Death	7 ^{9ay} 2007 ^{ear}	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Lo			4c. County of Dea	625P "
•	Examin	er	14740 Patuxent Ave.	Solomon			Calver	
#D	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	If Under 1 Year	f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		rthplace (State or Foreign Country)
	Director		216-12-4283					Maryland
	yland iow at		10a. State 10b. County 10c. City, Town or Le	ocation				10d. Inside City Limits
	a-f sh	ctor	Maryland Calvert Solomons	3				1 □Yes 2 □No
	or 28 be no	Dire	10e. Street and Number 14740 Patuxent Ave.	10f. Zip Code 20688			g. Citizen of What C	-
	eath v ns 23a must	Funeral Director			anic Origin? (Spe		14. Race - Am	
30	be filed within 72 hours after death with the Maryland ital Hygiene. dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fun	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No	Was Decedent of Hispi If Yes, specify Cuban, 1 ☐ Yes 2 ☐ No 8	Mexican, Puerto I Specify:	Rican, etc.)	Black, Wh	ite, etc.
12-0036	72 hou 'natura dical E	ted	15 Decedent's Education 16a Dece	dent's Usual Occupation	on		6b. Kind of Business	
7	ithin 7 ne. nan "r	Completed		kind of work done duri DO NOT use retired)				.] b
7	filed within Hygiene. ther than "		11 17. Father's Name (First, Middle, Last)	chasing a	B. Mother's Name			along boat
land	d be f ental f ked ol c eve	To Be	John Langley		Ida Mae		aideil Sumame)	
ary	2 should be and Mental Is marked (aumatic ev	-		ng Address (Street and			City or Town, State,	Zip Code)
e, Z	のもいる	1 0		Box 15 S	olomons	Maryl	and 2068	38
	ges 1 and 2 should t of Health and Mer If Item 27 Is marke or other traumatic		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition cemetery, cre	osition (Name of matory or other place)	:	1	0c. Location - City o	r Town, State
Бащтог	t. Pa rtmen rtant: njury			Star of the		metery s	Solomons M	Maryland
n D	permi Depa Impo any Is		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		Ran	sch Fune	eral Home	
E	STEW !		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying,	Such as cardinc o	Mary Lane r respir tory arres	1 20688 st,	Approximate Interval Between
d d	Physician	2 A	disease or condition	lular cuncer				Onset and Death
Ŀ	/Medical Examiner		resulting in death) Due to (or as a consequence of):					
	i udi	ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):					
	outed id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events					
Š	e execian an	EX	resulting in death) Last Due to (or as a consequence of):	-				
00/00	ificate be executed g physician and as the burial-transit	edical	d					
XOC		/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy				23d. Date of de	liven
0	The law requires that the death certate has been signed by the attending age 2 should be detached for use a	Physician/M	in the past 12 months? 1 Live birth 2 Li Fetal death 3L	□Ectopic pregnancy □ Other (specify)			Month	Day Year
Ţ.	that the ed by detac		Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given i	in Part I.	23e. Did toba	acco use contribute t	to the cause of death?
cords,	quires en sign uld be	ed by	Metautaine prostate concer			1 ☐ Yes	2 ⊡√N o 3 □ F	robably 4 □Unknown
2	law reas bee	Completed				24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
ב ב	The page	Com				perform	ed? death? □ Ho 1 □ Ye	_
\ [a	certific	Be	25. Was case referred to medical examiner?	Olli	6. Place of Death			
5	Phys	2	1 ☐ Yes 2 ☐ Mo			ne 5 Residen	nce 6 Other (Spe	ecify)
VISION O	nding th. r: Afte e fune	tion	1 ☑f\$atura! 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work?	s 2□No	od. Describe nov	vinjury occurred	
2	r Atte er dea recto	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, str building, etc. (Specify)	eet, factory, office	2	8f. Location (Stre	eet and Number or F	tural Route Number,
5	urs aft eral Di							
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge, deat (2 ☐ Medical Examiner: On the basis of examination and/or in and manner stated.	h occurred at the time, vestigation, in my opin	date and place, a lion, death occurre	and due to the cau ed at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier	29c. License nu		290	d. Date signed (Mon	
•	140		· lew)	1)5	6024		April 182	007
	1		30. Name and address of person who completed cause of death (Item 23a) (Type, Kenneth L. Alboth 110 Hosp. Text Road	Print) Sube 110	Prince Fr	edence t	11) 2067	14
ľ	Sta Registr		31. Date filed (Month, Day, Year) APR 1 9 2007 32 Registrar's Signature	rate s				
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DHMH 17 Rev 1/2001

			For State Registrar	State of Ma	arylan		artmen rtificate			and M	lental Hy	giene	in the ma	14559
	Dhysisi		1. Decedent's Name (First, Middle, L.	est)							2. Date of De Month	eath Da	y Year	3. Time of Death
	Physici /Medic		Betty Jay Mor	ris			,				April	28,	2007	11:26 A.M
	Examin	er	4a. Facility Name (If not institution, gi				_		Location of	of Death		4c.	County of Dea	ath
			53 East Bel Air					rdee		0411-0			rford	
	Funeral			Sex 7.Ag 1□M 2⊠F	e (<i>In yrs. 1</i> 63	last birthday) Yrs.	Months	1 Year Days	If Under: Hours	Min.	8. Date of Bi (Month, D) 12/30/	rth ay Year)	9. Bi	rthplace (State or Foreign
	Director		213-40-1356 Usual Residence of Decedent						l		12/30/	42	that?	yland
	land ow		10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
	Mary -1 sh	tor	MD Harfor	rd.	A	berdee	n							1⊠Yes 2□No
	1 the	Director	10e. Street and Number				10f. Zip	Code				10g. Cit	izen of What C	country?
	ath with the Maryla 23a or 28e-f show	Die	53 East Bel Air	Ave. Apt	. 23			210	01			τ	J.S.A.	
	deat	Funerai	11. Marital Status	12. Was Decedent		S. 13.	Was Deced	lent of Hi	spanic Ori	gin? (Spe	ecify Yes or Ne Rican, etc.)		14. Race - Am	
9	after or Ite	F	1 XNever Married 2 Married	Armed Forces? 1 Yes 2 Xi If Yes, Give	No		1 ⊡ Yes :		Specify:	i, rueno	nican, etc.)		Black, Wh	ite, etc.
8	ural'.	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:			1 0 1 0 3	ZXIVO	эрвопу.				Specify: Wh	ite
5-	be filed within 72 hours after de ital thygiene. Id other than "natural", or flems event, it e Medical Exertination	Completed	15. Decedent's £ (Specify only highest g	ducation ade completed)		16a. Dece (Give	kind of wo	rk done a	furina mosi	t of work	ing	16b. K	ind of Business	s/Industry
12	withir	dm	Elementary/Secondary (0-12)	College (1-4or	5+)		DO NOT US L Serv		,			TT C	Cort	
2	Hygie ther t		17. Father's Name (First, Middle, Las	t)		CIVI	r per	vice	18 Mothe	er's Name	e (First, Middle	-	S. Govt	•
au	ntai hed o	Be	Addison Pluff	,							Morris		oumano,	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 Ia marked other than "natural", or Items 23s or 28e-f show any injury or other treumatic event, If a Medical Examinational be redifficated and once.	ဥ	19a. Informant's Name/Relationship	(Tyne Print)		19h Mailir	na Address	(Street a					or Town, State,	Zin Code)
<u>R</u> a	d 2 s th an t7 la		Kimberly M. Mor		ter)		Engle				een, Ma			001
	1 an Heal tem 2		20a. Method of Disposition	, , , , ,	20b. P	lace of Dispo	sition (Nan	ne of	I		Date		ocation - City o	
٥	ages int of t: If It		1 ☐ Burial 2 ☑ Cremation 3			emetery, crer A. Fei				5/1/	07			
Baltimore,	artme artme orteni injury	. 1	 4 □ Donation 5 □ Other (Spec 21. Signature of Funeral Service Lice 		11.•								: Chest	er, PA
Ba	permit. Departr Import any inj		VIANEN A	V // NO	Vest	700 7	arrin	ig-Ca	irgo .	Fune	ral Hor 2100	ne, I	PA.	
			23a. Part1. Enter the disease, or cor	nplications that caused	the death	n. Do not ent	er the mod	e of dvino	z. such as	cardiac o	or respiratory a	rrest.	19	Approximate
	201		shock, or heart failure. List online immediate Cause (Final	one cause on each li	ne.									Interval Between Onset and Death
	Pnysician / /Medical		disease or condition resulting in death)			rdial								Innediate
	Examiner			Due to (or as	a consequ	uence of):	der	a 13	Ed of	4				2 years
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m-	execu n and al-tra	Exal	resulting in death) Last	C. Due to (or as	a consequ	uence of):								
8760,	Hospitel or Attending Physician: The law requires that the death certificate be executed 14 hours after death. Funeral Director: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	cail		. d										
ő	ificate g physias the	Pa												
Вох	eath certific attending p for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			-						23d. Date of de	alivery
m	death e atte d for	Cia	in the past 12 months? 1 ☐ Yes 2 2 No	1 ☐ Live birth 4 ☐ Pregnant a]Ectopic pr] Other (sp						Month	Day Year
P.O.	it the de by the tached	hys	9 Unknown	9□ Unknown							_			
	res that igned to be det	by P	Part II. Other significant conditions				nderlying c	ause give	n in Part I.		23e. Did	tobacco i	use contribute i	to the cause of death?
Ď	w require been sig should b		peripher	al Jascula	y di	scase					1/8	es 2	□No 3□P	Probably 4 Unknown
Division of Vital Records,	aw re s bec 2 sho	Completed	Atrial F	ibrillation							24a. Was		24b. Were a	utopsy findings available
R	The lav	Eo									auto perfe	ormed? 220No	death?	
ta	ician: Th certificate rector, pag	a)	25. Was case referred to medical						26. Place	of Deat!	h (Check only		1010	3 20110
<u>></u>	Physician: this certific al director,	ToB	examiner? 1 ☐ Yes % ☑ No	Hospital: 1 Inpatie	ent 2 🗆 I	ER/Outpatier	nt 3 DC	A Othe	er: 4 □ Nu				6 □Other (Sp	ecify)
0	ding Ph h. After th funeral		27. Manner of Death	28a. Date of Inju (Month, Da	ry v Year)	28b. Time of	2	8c. Injury Work			28d. Describe	how inju	ry occurred	
Ö	ofeath. ctor: Af y the fur	atic	1 Natural 5 Pending investigation	on	, ,	,,	М		res 2□	No				
<u> </u>	r Attencer death	tific	3 ☐ Suicide 6 ☐ Could not determine		ury - At ho	me, farm, str	eet, factory	, office			28f. Location			Rural Route Number,
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	To the Hospitel or Attent within 24 hours after death To the Funeral Director: completely filled in by the			hysician: To the best miner: On the basis o										
	To the H within 24 To the F complete	Medical	one)	and manner st	ated.									
	T with Co	~=	29b. Signature and title of certifier	0			290	. License	number	()		29d. Da	te signed (Mon	ith, Day, Year)
			, , , , ,	ruce (Y	2004	CUS				10-10	
	10		30. Name and address of person who	completed cause of c	leath (item	23a) (Type,	Print)	#41	2 A	her	leenm	9 2	1001	
			Prashant Shuk	19,40, 15	>. Ya	nce st	TCeT	()		7618	- [0/]			
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Physi	cian	Decedent's Name (First, Midd		_			-	2. Date of Dea Month	Day	Year	3. Time of D	
/Med	dical	Howard France 4a. Facility Name (If not institution))		4b. City, Town, or	Location of Death	April	27,	2007 by of Death	02:05	A ^v
Exam	iner	Upper Chesap			er	Bel-Air			Harf	•		
Funera Directo		5. Social Security Number 046–22–0818		ge (In yrs. Ia		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Jun. 5	, Year) , 1229	9. Birthpl Count Co	ace (State or I ry) nneticu	
and		Usual Residence of Decedent 10a. State 10b. Count	у	10c. City	Town or Lo	ocation				10	d. Inside City	Limits
Mary I-f sho	tor	MD Hari	ford	Fo	rest	Hill					1 ☐ Yes 2	. No
ith the	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Coun	ry?	
ath w	eral l	1 Colgate Driv		. F	140	21050			U.S.A	A.	on Indian	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Ma 3 ☑ Widowed 4 □ Divorce	If Yes, Give	? No		Was Decedent of His If Yes, specity Cubar 1 ☐ Yes 2 ☑ No		o Rican, etc.)	Bla	ack, White, e	etc.	
DCF 15-0	Completed		ent's Education est grade completed)		(Give	edent's Usual Occupa e kind of work done de DO NOT use retired)	uring most of wor	king	16b. Kind of I	Business/Ind	ustry	
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e filed al Hyg	Be C	17. Father's Name (First, Middle	e, Last)		-		18. Mother's Nan	ne (First, Middle,	Maiden Surna	me)		
Vlar Vlar Ments Ments arked	10 E	Unknown			1		Ruth Mi					
Maryland od 2 should be file that and Mental Hy 27 is marked oth	1	19a. Informant's Name/Relation				ing Address (Street a			-	n, State, Zip	Code)	
re, land Healt Healt tem 2		Judith M. Wali 20a. Method of Disposition			ace of Disp	Rustica Di osition (Name of ematory or other place		Date	20c. Location	- City or To	wn, State	
Pages nent of uny or		1 ☐ Burial 2 爲Cremation 4 ☐ Donation 5 ☐ Other (n 3 □Removal from State (<i>Specify)</i>	3	-	rris & Co.	i i	7/2007	West	Chest	er, PA	
Balti permit. Departr Importa	0100	21. Signature of Funeral Service	SUL	17	1:	2. Name and Address 23 S. Was	^{s of Facility} Mid hington	chell-Sn St. Hav	nith Fu re de	neral	Home,	P.A
		23a. Part1. Enter the disease, shock, or heart failure. Li	of complications that cause st only one cause on each	ed the death line.	. Do not en	ter the mode of dying	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Betwee Onset and De	
Physician /Medica	_	Immediate Cause (Final disease or condition resulting in death)				hrive				_		
Examine	_		Due to (or as	s a consequ	ence of):							
A 70 -	ner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events	b. Due to (or as	s a consequ	ence of):					101		
and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c		once off:							
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68760, cf. tificate be executed as the burial-transit	ledical		d									
P.O. Box hat the death cert ed by the attending detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 □Live birth 4 □ Pregnant a 9 □ Unknown	2 🗌 Fetal	death 3	□Ectopic pregnancy □ Other (specify)			I .	ate of delive fonth	-	ar
Cords, P. Www.equires that is been signed by should be detailed	by Ph	Part II. Other significant condi		but not resu	Iting in the u	underlying cause give	n in Part I.	23e. Did to	bacco use co	•		
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0 4 4 6	n: To	27. Manner of Death	28a. Date of In	jury	28b. Time of			28d. Describe h	_		7	
rision Attending death.	atio	Z Hoolden	stigation	ay reary			res 2 □ No					
or Att	Certification:	3 ☐ Suicide 6 ☐ Coule 4 ☐ Homicide deter	minod 286. Place of If	njury - At hor etc. <i>(Specify</i>	me, farm, st	treet, factory, office		28f. Location (S City or Tow		nber or Rura	Route Numb	er,
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical Ce	29a. Certifier 1 ✓ Certify (Check only one) 2 Medical	ving Physician: To the bes al Examiner: On the basis and manners	of examinat	vledge, dea ion and/or i	th occurred at the tim nvestigation, in my op	ne, date and place pinion, death occu	e, and due to the dirred at the time,	cause(s) and r date and place	nanner as st e, and due to	ated. the cause(s)	
To the within 2 To the comple	Me	29b. Signature and title of care	/			29c. License	number	2	29d. Date sign	ed (Month,	Day, Year)	
		· CXA	1	0		DIC	1583		April	27,	2007	7
\		30. Name and address of personance of person	Lazatin	mil). 8	Law S	+. Ab	urdee	n, m	02	001	
Regis	State strar	31. Date filed (Month, Day, Yea	2007 2007	trar's Signat	Sona	8. 3						

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 4/16/2007 $p^{\,\mathsf{M}}$ Irene Marcks 4:45 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Crofton Convalescent Center Crofton Anne Arundel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 12/18/1916 Days Hours 1 M 2 F 90 011-05-3649 Massachusetts Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Prince George 1 ☐ Yes 2 No Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12512 Shetland Lane 20715 USA Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 21XNo If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Specify: White 1 ☐ Yes XX No Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College₂(1-4or 5+) Customer Service Dry Cleaning 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jose Santos Aurora Conceicao 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mabel Strojny Daughter 12512 Shetland Lane Bowie, MD 20715 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial XX Cremation 3 ☐ Removal from State Metro Crematory 4/19/2007 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hardesty Funeral Home, P.A. Jatres 12 Ridgely Ave. Annapolis, MD 21401 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part1. Enter the disease, shock, or heart failure. L Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Herrs Due to (or as a consequence of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) sertensiv. Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 3 □Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 1 Matural 5 Pending investigation injury

Physician /Medical **Examiner**

Physician

Examiner

Funeral

Director

"natural", or Items 23a or 28a-f show dical Examiner must be notified at

the Medical

than

permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: If Item 27 is marked other the any Injury or other traumatic event, the once.

filed within 72 hours after death

Baltimore, Maryland 21215-0036

Box 68760.

Division or Vital Records, P.O.

Director

Funeral

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Completed

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Examiner

Physician/Medical

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Completed

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Certification:

Medical

The law requires that the death certificate be executed attending physician a for use as the burialsigned by the a page 2 s certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

IF FEMALE: 23b. Was decedent pregnant

2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

in the past 12 months? 1 ☐ Yes 2 No 9 Unknown

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier CNUTA MI

29c. License number

1 ☐ Yes 2 ☐ No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rakesh Arora, MD 14300 Gallant Fox Lane #222 Bowie, MD 20715

State Registrar 31. Date filed (Month, Day, Year) APR 1 9 2007

6 ☐ Could not be

32. Raistrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month **Physician** 14 Day April 2007 Dora F. Melton 4:21 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Yept. 20) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Year) 1 □ M 2 🔀 F 93 Chesterfield SC Director 250-40-1040 Usual Residence of Decedent 10c. City, Town or Location show 10a, State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f shov dical Examiner must be notified at New Carrollton 1. Yes 2 No Maryland Prince George's Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6015 Mentana Street 20784 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: African Amer. þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) Housewife Private permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If item 27 is marked othe any injury or other traumatic avera-18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Preston Funderburk Martha Dodson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) J. V. Melton/Son 6015 Mentana Street, New Carrollton, Maryland 20784 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Chesterfield County 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 XRemoval from State 4 □ Donation 5 □ Other (Specify) Goodman Creek Bapt.Ch 4/20/07 South Carolina 22. Name and Address of Facility Pope Funeral Homes, P.A. re of Fu 21. Signat 0/085 5538 Marlboro Pike, Forestville, Maryland 20747 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock/or heart failble. List only one cause on each min. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** neuman. /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Box 68760. Physician/Medical as attending IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 🗓 No Month 5 Other (specify) P.O. the 9 Unknown as been signed by 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1□ Yes 25 No Division or Vital 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) **A**G No 1 ☐ Yes 1 X Inpatient 으 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? (Month, Day Year) Injury 1 🔀 Natural 5 Pending 1 ☐ Yes 2 ☐ No I or Attendiafter death.

Director: A investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital c within 24 hours aff To the Funeral D 1 🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 9 - 19 - 9and title of certifier 29d. License number

Dy5660

29d. Date signed (Month, Day, Year)

Y-17-C7

Fox (N, 174 Bocso MD Ze71) 29b. Signature me and a dress of person who completed cause of heath (It 30C

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 2 0 2007

32. Registrar's Signatu

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Apri1 20, 2007 7:05 Carl Bradford Mullins a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Calvert Calvert Memorial Hospital Prince Frederick Birthplace (State or Foreign Country) 5. Social Security Number Age (In vrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Hours Min 1**∑**M 2□F 4/1/1942 65 Director 234-66-0353 WV Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits show r 28a-f show notified at 1 XYes 2 No Director MD Calvert Lusby 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code r than "natural", or items 23a or the Medical Examiner must be 12955 Parran Dr. 20657 USA 1 and 2 should be filed within 72 hours after death v Health and Mental Hygiene. em 27 is marked other than "natural", or items 23s Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Construction Rod Foreman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Dewey Mullins Beatrice Deem 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t. Pages 1 and 2 s rtment of Health ar strant: If item 27 is Linda Mullins/Wife 12955 Parran Dr., Lusby, MD 20657 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Injury or Department Important: If any Injury or once. 4/23/2007 Dunkirk, MD Memorial Gdns 22. Name and Address of Facility Raymond-Wood F.H., P.A. 21. Signature of Euneral Service Licensee 000 PO Box 430, Dunkirk, MD 20754 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Non-small month /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760, Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death
9 □ Unknown 23d. Date of delivery 23h Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) signed by the a d be detached for 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, δ. 1 Ves 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an page 2 s autopsy performed' ours after death.

neral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours at To the Funeral E Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0603 MD 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Adres Jaber 100 Hospital Rd. Frederick MD 20678 31. Date filed (Month, Day, 32. Registrans Signature Year) State APR 2 3 2007▶ Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 10:04 PM Stephen Ray Mosley April 18 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1**X** M 2□F 59 579-62-0326 Director Dec 26 1947 Tennessee Usual Residence of Decedent 10c. City, Town or Location 10b. County show 10d. Inside City Limits aţ "natural", or items 23a or 28a-f sh dical Examiner must be notified Director MD 1 ☐ Yes 2 XNo Lothian Anne Arundel 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? 987 Margarita Street 20711 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) filed withir Hygiene. College (1-4or 5+) 12 painter self employed marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) h and Mental F Be Ellis Mosley Juanita Grace Matheson Pages 1 and 2 should 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 Is any injury or other trat Darlene C. Mosley, Spouse 987 Margarita Street, Lothian, MD 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metropolitan Crematory 04-22-07 Alexandria, VA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility any in 20736 Rausch Funeral Home, P.A. Owings, MD 57 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Intra cerebral newworkings day s /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any heart to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine that the death certificate be executed burial-transit Due to (or as a consequence of): P.O. Box 68760 physician Physician/Medical the as attending IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No the 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has ! page 2 autopsy perform certificate 2 No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐ Yes 2**x** No 1 Inpatient 2 ER/Outpatient 3 DOA ÷ 1º this 27. Manner of Death 28a. Date of Injury 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Hospital or Attending (Month, Day Year) 1 Natural Injury the Funeral Director; Aff 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one)

State Registrar

the

2

29b. Signature and title of certifier

31. Date filed (Month, Day)

read Bech, My

30. Name and address of person who completed cause of death (Item 23a) (Type, Pont) but and address of person who completed cause of death (Item 23a) (Type, Pont) but and for the policy, My

32. Registrad Signature

29c. License number

D 46052

29d. Date signed (Month, Day, Year)

4/19/07

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 14^{Day} 2007 08:30A M Hildreth K. Morton April 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1274 Governor's Bridge Road Davidsonville Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 🛣 F Months Days Hours 216-44-5811 90 08/14/1917 Washington, D.C. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Maryland Anne Arundel Davidsonville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1274 Governor's Bridge Road 21035 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🏋 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🏋 No Specify. <u>Ş</u> Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Nurseryman</u> Nursev 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James H. Kempton Christine Collins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hildreth B. Clagett/Daughter 1212 Dicus Mill Road, Millersville, MD 21108 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Kalas Crematory 04/16/2007 | Edgewater, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signatura 22. Name and Address of FacilityGeorge P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. CORUNAR Immediate Cause (Final ARTER DISEASE disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Quality for as a ponsequence off cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2A No 25. Was case referred to medical 26. Place of Death (Check only one)

Physician /Medical Examiner

death certificate be executed

Box 68760.

P.O.

Division or Vital Records,

Physician

/Medical

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notifitied at any Injury or other traumatic event, the Medical Examiner must be notifitied at

Baltimore, Maryland 21215-0036

Examine attending physician and for use as the burial-tran Physician/Medical signed by the a d be detached f ð page 2 should Completed funeral director, Be P Certification:

certificate

After this

within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu

Hospital or Attending

Other: 4 Nursing Home A Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural Injury 2 Accident

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier Mak

3 Suicide

(Check only

29c. License number 24768 29d. Date signed (Month, Day, Year) 4-16-07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William Dabbs 277 Peninsula Farm Road, Arnold, Maryland 21012 31. Date filed (Month, Day, Year)

Registrar

Medical

APR 18 2007 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2045 */Medical 4c. County of Death 4b. City, Town, or Location of Death . Facility Name (If not institution, give street and number) Examiner WICOMICO 3 $\ni a$ lisbury CO If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 X M 2 ☐ F Yrs. 204-22-2123 73 1933 Pennsylvania Director May 6, Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show 1 ☐ Yes 2XX No r 28a-f sh notified Director MD Worcester Snow Hill 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number and 2 should be filed within 72 hours after death with a or or items 23a caminer must b 21863 U.S.A. 4912 Laws Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any Injury or other traumatic event, the Medical Examiner is 133Yes 2 No 1951− If Yes, Give Year or Dates: 1954 1 ☐ Never Married 2 X Married altimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: Specify: þ white 3 ☐ Widowed 4 ☐ Divorced 1954 Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Transportation 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George W. Marvel, Sr. Effie Mary Smith ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4912 Laws Road Snow Hill, MD 21863 Della Faye Marvel (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4-21-2007 Bates Cemetery Snow Hill, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Short Funeral Home 13 E. Grove Street Delmar, DE e. of Complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List druy are cause on each line. Approximate Interval Between Onset and Death 23a. Part1. En er the diseas shock, or hear failure. disease. Immediate Cause (Final disease or condition resulting in death) **Physician** Metastati /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760. Physician/Medical as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year for in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 2 □ No P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Sq. Division or Vital Records, Lun 20-No 3 ☐ Probably 4 ☐ Unknown 1 Tyes page 2 should Completed need 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy perform certificate 1⊟ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Yes No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 27. Magner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Natural 1 ☐ Yes 2 🗌 No To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completely filled in by the fu 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 026278 4mp WA

DHMH 17 Rev 1/2001

State

Registrar

Name and address of person who completed cause of leath (Item 23a) (Type, Print)

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2007

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gestalAs

gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day **Physician** 30, 2007 April 7:46pJuliana Nixon /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Frederick Frederick Memorial Hospital 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 😾 F Director 09-08-17 059-01-9014 New York Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10h. County show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hygiene. Inst: If item 27 is marked ther than "natural", or Items 23a or 23a-f show any or other traumatic event, the Medical Examiner must be notified at uny or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Frederick Frederick 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5955 Quinn Orchard Road 21704 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Medical Secretary Health Care 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henry Schilling Elsie Wineberg ... 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau 43 Glen Terrace, Stanford, Connecticut 06906 Julie Nixon/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Smithsburg Crematory May 2,2007 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur, of Fun ral Service idensee 22. Name and Address of Facility 504 Main Street Ricketts Funeral Home Myersville, Maryland 21773 23a. Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 5tovKB Day erebra valacular /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Liner Underly Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. physician and the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending pl IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? Day 4□Pregnant at time of death 5 Other (specify) signed by the a ☐ Yes 2 No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by No 3 Probabiy 4 Unknown ipertension 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Prhailetion 24a. Was an autopsy performed? Yes 2 No After this certificate has funeral director, page 2. 1□ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3□ DOA ၉ 27. Manner of Death Natural 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: / 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Hiren

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State Registrar 31. Date filed (Month, Day, Year)

MAY 0 4

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or rother traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at Baltimore, Maryland 21215-0036

1 - For State Registrar

Physician

/Medical

Examiner

Funeral Director

Physician /Medical Examiner

he law requires that the death certificate be executed To the Hospital or Attending Physician: he law requires that the death certificate be execut within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the tuneral director, page 2 should be detached for use as the burial-trar

Division or Vital Records, P.O. Box 68760,

· 4	1402 Knigh	htsbri	idge Turn			Croft	on			A	nne Aru	ndel
	5. Social Security Nun	nber	6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Y		er 24 Hrs.	3. Date of Birth (Month, Day)	Voor	9. Birth	place (State or Foreign
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	19a. Informant's Nam										r Town, State, Z	
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	20a. Method of Dispos	sition				sition (Name o		Da	ite	20c. Lo	cation - City or	Town, State
	21-		3 ☐Removal from	State C6		natory or other mont	piace)					
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	21. Signature of Fune	eral Service	Licensee		22	2. Name and A	ddress of Fac	ility Robe	rt E. H	Evan	s Funer	al Home
	allen	A	The		16	000 An	napoli	s Road	Bowie	MD	20715	
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Sic	1 ☐ Yes 2 ☐ N 9 ☐ Unknown	No	9□Unkr		,aiii 5_	Journel (specif	<i>''</i>					
by Physician/Medical Examiner									Γ			
>	Part II. Other significa	ant condition	ons contributing to d	leath but not resu	Iting in the ur	nderlying cause	given in Par	t I.	23e. Did tol	bacco u		the cause of death?
p									1 □ Y	es 2[□ No 3 □ Pr	obably 4 Dunknown
ete									04. 111		1	
힏									24a. Was a autops	sy	prior to c	topsy findings available completion of cause of
ģ									perform	neg? 2 Z No	death? 1 ☐ Yes	2□No
Be Completed	25. Was case referred	d to medica	ı				26. Pla	ce of Death	(Check only on	e)		
	examiner? 1 ☐ Yes 2 X No	0	Hospital:	Inpatient 2 1	R/Outpatien	it 3 DOA	Other:	Nursing Hom	. /		6 □Other (Spec	264
Ē.	27. Manner of Death		28a. Date		28b. Time of				Bd. Describe ho			шу)
o l	1 Natural	5 Pendin	ng (Mor	nth, Day Year)	Injury		Injury at Work?	_	od. Describe in	ow injui	y occurred	
Sati	2 ☐ Accident	investion 6 ☐ Could	not ho				1 Yes 2					
Ĕ	3 ☐ Suicide 4 ☐ Homicide	determ	singer 28e. Place	e of injury - At hor ling, etc. <i>(Specify</i>		eet, factory, of	ice	28	3f. Location (Si City or Town			ral Route Number,
Ę.	_			J, (,),	,				0.19 0. 1011	, 0,1210,	,	
Medical Certification: To	29a. Certifier 1.	☐ Certifyir	ng Physician: To the	e best of my knov	vledge, death	n occurred at ti	ne time, date	and place, a	nd due to the c	ause(s)	and manner as	stated.
<u>i</u>	(Check only 2 one)	☐ Medical	Examiner: On the I	basis of examinat nner stated.	ion and/or in	vestigation, in	my opinion, d	eath occurre	d at the time, d	late and	l place, and due	to the cause(s)
Mec		la of a - wif -		mor stated.		200 11	ense numbe	,		04 5	a alamad /Ad	Day Vans'
===	29b. Signature and tit	ile or certifie	T .	()		I			I .		e signed (Montl	i, Day, Year)
	> */. /	ou	use	X			0060	236	9	4	113/0-	7
	30. Name and addres	s of person	who completed cau	se of death (Item	23a) (Type	Print)				ı	113/0-	•
	il-11	T		,		11005	Ca10	11 00	action 1	11	21111	
	MEIDIE.	10WIN	SENU IVI		84 VI	WHOR	OKER	~ CA	NETON /	VII)	41114	
te	31. Date filed (Month,	R 19	2007	Registrar's Signat	K A	and s						
ar	AY	KID			19							

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No.

3. Time of Death

1400

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ∏Yes 2 ☐ No

ΜD

USA

Month

29d. Date signed (Month, Day, Year)

Day

3 ☐ Probably 4 ☐ Unknown

2007

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

Year

Black, White, etc.

white

MD 21532

Approximate Interval Between Onset and Death

MD

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours a

> State Registrar

completely

Medical

29a. Certifier

(Check only one)

31. Date filed (Month,

29b. Signature and title of certifier

MAY 0 4

IRGINI

Vais mui mo

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 😿 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Amend #14 Per State of Maryland / Department of Health and Mental Hygiene FH G867 5/16/07 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Apr 28, 2007 Powell 0945 Louise Alma /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Neme (If not institution, give street and number) Examiner Allegany Allegany County Nursing Home | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. | Min. | Jun 1, 1921 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months vintry) 1 □ M 2√2 F Vre 236-48-3552 Director Usual Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumetic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Yes 2□No Cumberland MD Allegany Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21502 USA 730 Furnace Street Funeral 14. Race - American Indian, Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No **Black** 1 Never Married 2 Married Specify: White 1 ☐ Yes Z☐ No Specify: Baltimore, Maryland 21215-0020 If Yes, Give Year or Dates: δ X□ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pauline (Allen) Spencer James R. Robinson 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 428 Pine Avenue Cumberland MD 21502 Janet Powell dau-in-law 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State 5/1/2007 Restlawn Memorial Gardens MD LaVale 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** cerebro Vasular Accident /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours either death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Inneral director, page 2 should be detached for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) 23b. Did tobacco use contribute to the ceuse of deeth? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Dementin 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown ۾ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? Be Completed 1 Yes ZLIN 1 □ Yes 2 □ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 5 Pending investigation 1-ENatural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Technifying Physician: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and tile of certifier D0033280 30. Name and addr ss of person who completed cause of deeth (Item 23e) (Type, Print) M.D.; GAS KENTAVE. CUMBERLAND, MD 21502 6 SUNIL 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar MAY 0 4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Dorothy P. Phipps ,2000 DYI /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Doctors Community Hospital Lanham Prince George's If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 □ M 2 □ XE 579-18-0657 92 10/05/1914 Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 X No Director Maryland Prince George's Riverdale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6605 Patterson Street 20737 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 五No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 💢 No <u>ک</u> 3 XWidowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Post Office 12 Mail Sorter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Steptoe Keith Payne Elizabeth Karn ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Phipps/Son 6605 Patterson Street, Riverdale, Maryland 20737 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 ☐Removal from State Arlington National Cemetery 05/02/2007 Arlington, Virginia 4 □ Donation 5 □ Other (Specify) 21. Signature | Fungral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Road, Oxon Hill, Maryland 20745 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac order, irratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a con equence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 4 Unknown 1 🗌 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 3 DOA 1 ☐ Yes 1 Inpatient Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, p

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar. Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Physician /Medical

Examiner

ed by the attending physician and detached for use as the burial-tran

Baltimore, Mafyland 21215-0036

Medical

State Registrar 29b. Signature and title of certifier

32. Registrar's Signature

29c. License number 126

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d, Date signed (Month, Day, Year)

rson who completed cause of death (Item 23a) (Type, Print) 30. Name and address of p

AMMADOLII LS RICHAM E 9500

31. Date filed (Month, Day, Year)

29a, Certifier

APR 23 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend line 7 per fd aaco hlth dept 4/19/07 dlw State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** April 14 2007 3:15P Gladys B. Pack /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel 145 Pineview Ave Severna Park 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours 1 ☐ M 21 F 1921 Virginia July Director 219-28-8581 85 Usual Residence of Decedent the Maryland 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or itame 23a or 28e-f ahow the Madical Examiner must be notified at 1 ☐ Yes 2 X No Maryland Anne Arundel Severna Park Directo 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 145 Pineview Ave 21146 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status hours after 1 [Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black þ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 6th Cook Daycare permit. Pages 1 and 2 should be filed to Depertment of Health and Mental Hygie Important: If item 27 is marked other tany Injury or other treumatic avent. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Willis Martha Lantern 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21146 19a. Informant's Name/Relationship (Type, Print) Carrie Nolan(Daughter) 307 Cattail Passage Ct. Severna Park, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4-20-07 Crownsville, Md. Maryland Veteran 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Williame Reverse of Ballisons Mortuary, P.A. 821 West St. Annapolis, Md. 21401 Larry & Neese MOG 483 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician cancer, unknown pr, mai Metastatic 10ars /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ettending physicien and for use as the burial-transit be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Dav 4☐ Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signe should be þ 1 Yes 2 No 3 Probably 4 Nown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has page 2 autopsy performed 1□ Yes 2□No Hospital or Attending Physicien:
24 hours after death.
 Funerel Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 | Inpatient 2 | EP/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 12 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 29a. Certifier 1 dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2 To the the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Veterans Huy Millers ville, MD 21108 Name and address of person who completed cause of death (Item 23a) (Type, Print) enniter KIE 31. Date filed (Month, Day, Year)
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Registrar

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Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

31. Date filed (Month, Day, Year) State APR 2 0 2007 Registrar

29b. Signature and title of certifier

Centhia M Milliams DO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



29c. License number

H0058032

29d. Date signed (Month, Day, Year)

April 19,2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Parran **Physician** Lily 7,2007 0339 Apri1 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Prince Frederick Calvert Memorial Hospital If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days 1 □ M 2 □ F 73 215-38-4235 MD Jan.23,1934 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County rthen "netural", or Iteme 23a or 28a-f ehov The Modical Examiner must be notified at 1 ☐ Yes 2 ☑ No MD Calvert Huntingtown Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20639 USA 3355 Bayside Road Be Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☐ No Specify: 3 ₩Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Cook Restaurant permit. Peges 1 and 2 should be filed Deperment of Heelth and Mental Hyg Important: if Item 27 ie marked other eny injury or other traumatic event, i 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Holland Clarence Beatrice 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17519 Wild Cherry Lane King George, 19a. Informant's Name/Relationship (Type, Print) King George, VA Barbara P. Buchanan/daug. 20b. Place of Disposition (Name of cemetery, crematory or other place)
E. Jones Cem. 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/25/07 Ches. Bch., MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Sewell Funeral Home 20678 Blody a 1451 Dares Beach Road Prince Fred., MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Conquition /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed the attending physicien and hed for use as the burial-transit CAN Due to (or as a consequence of): P.O. Box 68760, HYN IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a 1 ☐ Yes 2 12No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No been 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No certificete 1 Yes 2 1 No Division of Vital the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 R/Outpatient 1 ☐ Yes 2 ☑ No ဥ 3□ DOA this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physicians To the best of my knowledge, death occurred at the time, date and place, and due to the cauce(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Cortilior

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Shal

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MM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registra Signature

Hosp

29c. License number

RD

D 50290

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29d. Date signed (Month, Day, Year)

20678

			1 - State State O		eartment of Health and Mertificate of Death	lental Hygier	ZUUI	1:574
4.5	Physici	an	1. Decedent's Name (First, Middle, Last)				2007	3. Time of Death
	/Medic	al	Evelyn D. Pfister 4a. Facility Name (If not institution, give street and number 1)	nharl	4b. City, Town, or Location of Death	April 11	4c. County of Death	4:30 p ^M
4	Examin	er	National Lutheran Home	nber)	Rockville		Montgomer	v.
3.5	Funeral	- A	5. Social Security Number 6. Sex	7. Age (In yrs. last birthday		8 Date of Birth	9 Right	place (State or Foreign
É	Director		350-03-9691 1□M 2□XF	87 Yrs.	Monday Jaya	8/16/19	Micl	nigan
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation			10d. Inside City Limits
	the Marylan 28a-f ehow	tor	MD Montgomery	Rockv	rille			1 ■ Yes 2 □ No
	or 28	Direc	10e. Street and Number		10f. Zip Code	10g. (Citizen of What Cou	ntry?
	s 23a	rail	9701 Veirs Drive		20850	- W. W N.	USA	an Indian
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other then "natural", or Items 23s or 28s-1 ehow other treumatic event, ite Madical Examinat must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Dec. Armed Fe for 1 ☐ Yes If Yes, Gir Year or D	2 [XNo	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:	ecity Yes of No- Rican, etc.)	14. Race - Americ Black, White,	
5-0	natural',	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deci	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)	ing 16b.	Kind of Business/In	dustry
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d 2	filed v Hygie other I		17. Father's Name (First, Middle, Last)	OLLI		e (First, Middle, Maid	len Sumame)	
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Maryland	and h		19a. Informant's Name/Relationship (Type, Print)		ling Address (Street and Number or Run			
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Balt	permit. Page Department o Important: if eny injury or once.		21. Signature of Funeral Service Licensee	hlu &	22. Name and Address of Facility Jurphy FH 4510 Wils	on Blvd.	Arl., VA	22203
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Vita	Physician: The raths certificate hiral director, page	Be	25. Was case referred to medical examiner?		Other	h (Check only one)		
ot	Phys r this ral dir	5	1 105 2 PNO	npatient 2 ER/Outpatient 28b. Time	ent 3 DOA 4 Urbrarsing Ho	me 5 Residence 28d. Describe how in	6 ☐Other (Special	fy)
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amir		4a. Facility Name (If not institution, give street and number)		4b. City,	Town, or Loca	ation of Death		4c.	County of D		
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atice	ဥ	Walter Randall			C:	laudia	Smit	h			
ma,		19a. Informant's Name/Relationship (Type. Print)		Mailing Address							
her tı		Roland J. Queene(Son)		12 Bay							
any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Memor	Disposition (Nan Aldrenhalbry or o ial Ga	rdens	4-19	ł	Davi	dson		, Md.
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3 Suicide 4 Homicide 5 See Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 5 State Registrar 5 State 1 Suicide 4 Homicide 6 Could not be determined 6 City or Town, State) 29a. Certifier (Check only 2 Medical Examine) 9 On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 9 On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 9 On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 9 On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 9 On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 9 On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 9 On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 9 On the basis of examination and/or investigation, in my opinion, death occ	nding ath. r: Afte e fune	atlor	1 Natural 5 ☐ Pending (M	onth, Day Year)	Injury							
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Physician /Medical Examiner	4 - 7 4	REARDON	mber)	4b. City, Town, or	Location of Death	2. Date of Death Month APRIL 2.	Day Yea	10:00 A M
Funeral Director		ER HOSPITAL 6. Sex 1 XM 2 P	7. Age (In yrs. last birthda) 64 Yrs.	CHESTE // If Under 1 Year Months Days	RTOWN If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 01/28/1	KENT 943	Birthplace (State or Foreig Country) NY
the Maryland 28e-f show notified at	3470	ent County KENT	10c. City, Town or I					10d. Inside City Limit
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5-UU30 72 hours after death with the Maryland 72 hours after death with the Maryland 72 hours after 23e or 28e-1 show dical Examination must be notified at eted by Funeral Director	3 ☐ Widowed 4 ☐ Div	Armed Fo	2 □ No ve	. Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black, W	merican Indian, /hite, etc. WHITE
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ath. or: After the funera	27. Manner of Death 1. Natural 5 F 2 Accident	rvestigation	of Injury th, Day Year) 28b. Time of Injury	Work	at 2 es 2 □No	8d. Describe how	v injury occurred	
To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2: Medical Certification; To Be Compl	3 Suicide 6 0	could not be etermined 28e. Place building	of Injury - At home, farm, sing, etc. (Specify)	treet, factory, office	2	8f. Location (Stre City or Town,	eet and Number or State)	Rural Route Number,
the Hospl thin 24 hou of the Funer impletely fill		cical Exeminer: On the ba	best of my knowledge, dea asis of examination and/or in her stated.	th occurred at the time nvestigation, in my opi	e, date and place, a nion, death occurre	nd due to the cau d at the time, dat	use(s) and manner te and place, and d	as stated. ue to the cause(s)
To the vithing To the company	29b. Signature and title of c	ertifier		29c. License	number	290	d. Date signed (Mo	nth, Day, Year)
15	30. Name and address of po	erson who completed caus	e of death (Item 23a) (Type	D643	888		419	14107
State Registrar	MAHhew Ki 31. Date filed (Month, Day,	—	Speer Road	d Cheste	ertown	HD 9	1620	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2007 **Physician** рм April 18, 8:25 Kathleen Rodgers Jeanne /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery 9. Birthplace (State or Foreign Spring Mos. 8. Date of Birth (Month, Day, Year) Gardens at Riderwood Village Renaissance
5. Social Security Number **Funeral** Days Hours Min. 1 M 2 3xF 1Ó. Iowa 480-30-7377 Aug. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10a. State 10c. City. Town or Location show ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2X No Director Maryland Montgomery Bethesda 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 10630 Montrose Avenue, #204 20814 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 Specify White 1 ☐ Yes 2 🕱 No Specify: ρ 'natural', % Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) the Education Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fill ment of Health and Mental Hant: If item 27 is marked oth jury or other traumatic even Be Charles O. Todd Charlotte Faulkner ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) 10630 Montrose Avenue, # Alison Rodgers/Daughter #204, Bethesda, MD 20814 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c Location - City or Town, State April Department of Important: If it any Injury or o 1 ☐ Burial 2 🔀 remation 3 ☐ Removal from State Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2007 Alexandria, Virginia 21. Signature of Funeral Septice 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. Myan 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 4 Years Alzheimer's Disease /Medical Due to (or as a consequence of): Examiner Adult Failure to Thrive Sequentially list conditions, Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-trar Due to (or as a consequence of): Box 68760, physician be Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) P.0. the 2 9 Unknown 9 Unknown by signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To this fureral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred A ler t ospital or Attending hours a er death. 1 🔀 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours a er death Funeral Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide Hospital t⊈l Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29c. License number 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier D59524 April 19, 2007 luthu mans 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3110 Gracefield Road, Silver Spring, MD 20904 Loveen Puthumana. M.D. 31. Date filed (Month, Day, Year)
APR 2 0 2007 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 200

		-	State of Maryland / Department	ent of Health and N <i>ate of Death</i>		giene Reg. No. 🤈 🗎 🗎 🗎	
			Registrar 1. Decedent's Name (First, Middle, Last)		2. Date of Dea	ath	3. Time of Death
	Physicia		ELIZABETH ROYAL		Month O4	Day 2007	13:57 M
1	/Medic Examin	-	4a. Facility Name (If not institution, give street and number) 4b. C	ity, Town, or Location of Death		4c. County of Dea	th
E.		•	Peninsula Regional Medical Center S	palisbury		Wicom	100
4	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Ur	nder 1 Year If Under 24 Hrs. hs Days Hour Min.	8. Date of Birtl (Month, Day	r, Year) Co	thplace (State or Foreign ountry)
	Director		241-88-2106		8-24-19	950 Ohi	_0
	and www.	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	Maryl f sho	호	MD Wicomico Salisbury				1 ☐ Yes 2 ☐ No
	r 28a	iec		Zip Code		10g. Citizen of What Co	ountry?
	h with	<u>=</u>	27409 Nanticoke Road	21801		USA	
	deat	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was D Armed Forces? 13. Was D If Yes,	ecedent of Hispanic Origin? (Sp specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - Ame Black, Whi	
36	be filed within 72 hours after death with the Maryland tial Hygliene. 8d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fu	1 □ Never Married 2 N Married 1 □ Yes 2 N No	s 2⊠ No Specify:		Specify: W	
15-0036	2 houra	pel	15 Decedent's Education 16a Decedent's	Jsual Occupation		16b. Kind of Business	/Industry
212	hin 7% an "na Medi	Completed	(Specify only highest grade completed) (Give kind on life. DO NC) Elementary/Secondary (0-12) College (1-4or 5+)	f work done during most of wor T use retired)	king		
7	d wit	ě	4+ Teach			Board of E	ducation
Maryland	e e e	Be (17. Father's Name (First, Middle, Last)			Maiden Surname)	
<u>X</u>	2 should be and Mental and Mental Is marked or raumatic eve	2	Walter McDonald		Barkman		
<u>a</u>	12 sh n and rism raum		, , , , , , , , , , , , , , , , , , , ,	ress (Street and Number or Ru			, ,
	es 1 and 2 should b of Health and Ment fitem 27 Is markec r other traumatic e		20a Method of Disposition 20b. Place of Disposition	nticoke Road,	Salisbu Date	ry, MD 2180	
و			1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State	i i	0 2007	D-1 D-	1
Baltimore,		1	4 □ Donation 5 □ Other (Specify)			Delmar, De neral Home	laware
ä	permit. Departr Imports any inj	<u>.</u>	1 - 46 , Bloka	E. Main Street			804
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•	/Medical		resulting in death) a	, , ,			
i.	Examiner		Sequentially list conditions, b.				
	sit s	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
	xecuti and Il-tran	Examiner	that initiated events resulting in death) Last C				
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68/	ificate g phyas as the	edical	0.			N10	
Box	h cert anding use a	M/u	IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectop	oic pregnancy		23d. Date of de	*
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Ś	The law requires that the death certificate has been signed by the attending lagge 2 should be detached for use as	þ	CON & STATE Seguit Confine	ing cause given in r air i.	1 🗆 '		Probably 4 □Unknown
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g	n: Th		25. Was case referred to medical	26. Place of Dec	1□ Yes ath (Check only o	2 No 1 Ye	s 2□No
\equiv	sicia s certi lirectc	o Be	examiner?	Other:		dence 6 □Other (Sp	ecify)
0	ding Phys n. After this funeral di	H-	27. Manner of Death 28a. Date of Injury 28b. Time of	28c. Injury at Work?		how injury occurred	
<u></u>	ath. r: Aft	atio	2 Accident investigation M	1 Yes 2 No			
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	ospital or / hours after uneral Dire		the state of the s	ared at the time date and place	and due to the	and manner	a alpiad
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate hy completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge, death occu				
	o the vithin : o the omple	Mec	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mor	nth, Day, Year)
)	NN		Kordney a Werrich m.D.	D 15384	,	4/19/	2007
	V MA		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Y MD 21804	Rod	ney A. Wie	enrich
_	. 10		1346 S. DIVISION ST. SALISBUR	1 WD 51800	†)	
	Sta		31. Date filed (Month, Day, Year) 32. Pogistrar's Signature	ø.			
	Regist	ar	APR 2 0 2007 Brene & Spen	v			

		1	For State Registrar	State of Maryland		artment of H rtificate of I		-	giene Reg. No.	007	7 2	580
4	Physicia	_	1. Decedent's Name (First, Middle, Last		***			Date of Dea Month	Day	Year	3. Time o	
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74/2	Funeral		5. Social Security Number 6. Se	x 7. Age (In yrs. I	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt	b		ace (State	or Foreign
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2	w Dw	ŀ	Usual Residence of Decedent 10a. State 10b. County	,	, Town or Lo					10	Od. Inside C	City Limits
400	rivery	ţċ	MD Allega	ny	Cun	nberland					¹ X Yes	s 2∏No
4	or 28	Director	10e. Street end Number			10f. Zip Code	0.4500		10g. Citiz	en of What Coun	try?	
	s 23a s 23a nust b		13813 Brant Road	12. Was Decedent Ever in U.	2 12	Was Dagadant of H	21502	ecify Vec or No	. 1	USA 4. Race - America	an Indian.	_
- 4	items items iner n	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?			ispanic Origin? (Span, Mexican, Puerto	Rican, etc.)		Black, White,		
3-003p	be filed within 72 hours arier death with the Maryaniu tall Hygiene. Ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	3 Midowed 4 Divorced	If Yes, Give Year or Dates:		1 □ Yes 2 □ No	Specify:			^{Specify:} whi	te	
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7	riled within Hygiene. other than " ont, the Med	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)		emaker	1)		Ow	n Home		
ט מ	Hygi other ent, tl	Be Co	17. Father's Name (First, Middle, Last)				18. Mother's Name			,		
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e i	0 0 - L		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	lace of Dispo emetery, cre	osition (Name of matory or other place Ineral Home	ce) D Δ	Date 5/1/2007		cation - City or To		MD
ב ב	t. Fages tment of tant; If it		4 □ Donation 5 □ Other (Specify)	·				CI	esaptow	·	UID
n n	permit. Pag Department Important: I any Injury o once.		21. Signature of unetal Service Licen	LUIM	-		กิ คืนก็ยี่เล่ Ho ginia Avenue:		nd, ME	21502		
П	- 451		23a. Patri. Enter the disease, or compositions of heart failure. List only	olications that caused the death	. Do not en	ter the mode of dyir	ng, such as cardiac	or respiratory a	rrest,		Approxima Interval Be Onset and	ate etween
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	/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):							
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/ISI	Atten	fical	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At ho	ome, farm, st	treet, factory, office		28f. Locetion (City or To		d Number or Rura	al Route Nu	umber,
	tal or s after al Dire	Certification:	4	building, etc. (Specif	y <i>)</i>			Only of 10	www. Diate,			
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director;	Medical (29a. Certifier 1	ysician: To the best of my kno niner: On the basis of examina and manner stated.	wledge, dea ition and/or i	th occurred at the t nvestigation, in my	ime, date and place opinion, death occu	, and due to the irred at the time	cause(s) , date and	and manner as s place, and due to	tated. o the cause	e(s)
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			Mobustimo	y. Haner.	MD		D14865		APR	21L 28	=, $=$	1001
	2		30. Name and address of person who BARRERA, ROBUSTIA	ANO J., M.D.,	500 ME	, Print) MORIAL A	VENUE, SU	ITE 201	, CUM	BERLAND	, MD :	21502
6.	St Regist		31. Date filed (Month, Day, Year)	22. Registrar's Signa	ature	de						
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Registrar DHMH 17 Rev 1/2001

			Please	Type or Prin						_) .
		For State		State of Ma	aryland	,	artment of F rtificate of		,	0.00	7 11.591
		1. Decedent's Nam	e (First, Middle, La	st)				Dealli	2. Date of De		3. Time of Death
Physic /Med		John J	oseph Suc	ggs					Month 4	2/ Ye	1630 M
Exami		11 ' ;	//	e street and number)	0.	4:00		Location of Deat	h	4c. County of E	
Funeral		5. Social Security N		AL MEDKA Sex 7. Ag	e (In yrs. las	HER at birthday)	_If Under 1 Year	SURY If Under 24 Hrs	. 8. Date of Bir	th 9.	Birthplace (State or Foreign Country)
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rland ow		Usual Residence of 10a. State	10b. County		10c. City,	Town or Lo	ocation				10d. Inside City Limits
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with than or 28	Director	10e. Street and Nu	_{mber} kside Rd.				10f. Zip Code 218	11		10g. Citizen of Wha	: Country?
ms 23	Funeral	11. Marital Status	KSTUE KU	12. Was Decedent	Ever in U.S.	13.	Was Decedent of H If Yes, specify Cubi		Specify Yes or No		merican Indian,
Datuillofe, Ivial yiallo 4 14 13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any nice.	by	1 □ Never Marr 3 □ Widowed	ried 2 ∑ Married 4 ☐ Divorced	Armed Forces? 1 X Yes 2 □ I If Yes, Give Year or Dates:	No MMI	T	1 ☐ Yes 2 ☑ No		to Hican, etc.)	Specify: W	vhite, etc. hite
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	by Pt	-	1700	contributing to death b	ut not resulti	ing in the u	ınderlying cause giv	ren in Part I.			te to the cause of death?
law requires t as been signe 2 should be	eted	ASCV	Two Dif	٢٠٠٠/١٩ (د	1177						Probably 4 Unknown
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VICAL Iclan: T Sertificat ector, pa	Be C	25. Was case refe examiner?	rred to medical			-			1 Yes ath (Check only	2 ☑ No 1 □ one)	Yes 2□No
Physic Physic rthis ce	2	1 ☐ Yes 2 ☐		Hospital: 1 Inpatie		R/Outpatie	nt 3□ DOA Oth	4 Li Nuising i	1	idence 6 Other (Specify)
storial state. tor: After the funer	tion	1 Natural 2 Accident	5 ☐ Pending investigatio	(Month, Da	y Year)	Injury	Wo	rk? Yes 2∐No	Zou. Describe	now injury occurred	
r Atter er dea lrector	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	20e. Place of inj	jury - At hom tc. <i>(Specify)</i>	ie, farm, st	reet, factory, office			(Street and Number of	r Rural Route Number,
pital o		29a. Certifier	1/9 Certifying P	hysician: To the best	of my knowl	ledge deal	th occurred at the ti	me date and place	e and due to the	cause(s) and manne	or as stated
ne Hos n 24 ho ne Fun oletely	Medical	(Check only one)		miner: On the basis of and manner st	of examination						
To the within To the comp	ž	29b. Signature and	d title of centifier	7			29c. Licens			29d. Date signed (A	
		20 N	W.	completed cause of c	looth (It C	220) /T		4534 Al Faldo	M D	4/25/07	
BAIOH		Name and add	`	woll stre	et:	Salis	bury, Md.		r, Pi.D.		
S	tate	31. Date filed (Mo		32. Registr	rar's Signatu	re H	book				
Regis	ırar		APR 2 3 2	OUT DING	u s	5 19					

07-03130	Please Type of Print in Black Indelible ink. Ensure All Copies Are Legi
Christopher C. Smith	State of Maryland / Department of Health and Mental Hygiene

		I- For State Registrar	, , , , , ,	Certific	ate of Deal	th		R	eg. No.	007 1	.58
Physicia	n/	Decedent's Name (First, Middle	Last)					2. Date of Dea	th Day Ye	3. Time of Dea	
Medical Examin	ier	Christopher	Clark	Smith				April 24, 2	2007	1844 nrs	s .
dr.		4a. Facility Name (if not institution Calvert Memorial Hosp	•			Town, or Lo ce Freder	cation of De	eath	4c. County Calvert		
Funeral		<u> </u>		e (In yrs. last bir			If Under 24	Hrs. 8. Date of Bi	rth(MM/DD/YYY		or
Director	- 1		1 X M 2 F		Month			Min.	•	Foreign	DC
	ŀ	Usual Residence of Decedent	1 <u>X</u> M 2_F	47	Yrs.			LOCT.	23,1959	Couwashin	igton
any	ı	10a. State 10b. County		10c. City, Towr	or Location				·. ·· · · · · · ·	10d. Inside Ci	ity Limits
~ ≥	۲	MD Calve	ert	North	Beach					1 X Yes 2	2 No
Maryland 28a-f show d at once.	Director	10e. Street and Number			10f. Zij	p Code			l0g. Citizen of W	hat Country?	
with the Maryland ns 23a or 28a-f sho		4012 2nd Str	reet			20	714		U.	S.A.	
h with	uneral	11. Marital Status	12. Was Decedent Armed Forces?					(Specify Yes or No erto Rican, etc.)		e - American Indian, Bla te, etc.	ack,
after death 'al'', or iten	핆	1 Never Married 2 X Mai	1 Yes 2	X No		_		ono moan, cic.,	1	, 0.0.	
s afte rraf",	۾	3 Widowed 4 Divo	rced If Yes, Give Year or Dates:	related) 16a	1 Yes 2 Decedent's Usual	X No		of work done	Specify:	white usiness/Industry	
2 hour	ompleted	Elementary/Secondary (0-12)	College (1-4 or		during most of wo	rking life. D	O NOT use	retired)	Tob. Killd of B	usiness/industry	ļ
36 thin 72 than "		,,	2	·	andscape	r			landso	aning	
15-0036 filed within 7 ll Hygiene. ed other than 14, the Medica	Ö	17. Father's Name (First, Middle, I			unaboupe		.Mother's Na	ame (First, Middle,			
21215-000 ould be filed with Mental Hygiene marked other file feevent, the Mec	å	Gerald Richar					Patr	icia	Schultz		
D 21 hould Me is ma	유	19a. Informant's Name/Relationsh	ip (Type, Print)	1.0						wn, State, Zip Code)	- 17
Pages 1 and 2 should be filed within 72 hours after death with the Maryland near of Fleeth and Mental Hygiene. Jant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	-	Melissa A. Smit	h, wife		of Disposition (Na			Beach, M	4D 2071	- City or Town, State	
Ore of He If ite		1 X Burial 2 Cremation	3 Removal from Sta	ate crema	tory or other place	e)					
		4 Donation 5 Other Spe		Resur	rection	Cemet	ery 0	4-30-200	Clinto	n, MD	
Balt permit. Departi Import		21 Secture of Funeral Service I	t X	/	22. Name and	Address o	Racility R	ausch Fu	neral Ho	me, P.A.	
Physician	1	23a. Part I. Enter the disease, or o		the death. Do n	1 8325 M	т. на	rmony	Lane. U	vinas. M	ID 20736	e Interval
/Medical		failure. List only one cause of	n eachline. a. Dilated card	tionwonat	hv					Between Or Deat	
Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conse		,						
		Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):									
	ine	cause. Enter Underlying Cause	Due to (or as a conse	equence of):							
	Examine	(Disease or injury that initiated events resulting in death) Last		Due to (or as a consequence of):							
760, Icate be executed physician and the burial - transit			d								
0, be ex sician	/Medical	X UNPENDED	₩532,27, per			Π					
68760, certificate be nding physic se as the bur	-	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcor			3	Ectopic pre	egnancy	23d. Date of Month		Year
Sox 68 death certiff	cia	past 12 months?	4 Pregnant at	At 6 - 1 Ab-	5 Other (Spe			,g.10.10)		22,	
Box e death c the atten	Physiciar	1 Yes 2 No 9 Unkr	9 Oliknowii								
that the detach	습	Part II. Other significant condition	ons contributing to death	n but not resultir	ng in the underlyin	g cause giv	en in Part I.		-	tribute to the cause of de	
Records, P.C The law requires that cate has been signed b								_			
ord aw rec as bee	Completed							24a. Was	psy	Were autopsy findings prior to completion of cadeath?	
Rec The I	팃								ormed? 2 ✓ No	1 Yes 2	No
tal certification:	Be C	25. Was case referred to medical examiner?	Hospital:			0	ther:	eck only one)			
Physical direction	2	1 ✓ Yes 2 No 27. Manner of Death		nt 2 🗸 ER/0				rsing Home 5	Residence 6	Other:	
Division of Vital Records, P.O tat or Attending Physician: The law requires that t is after death. *I Director: After this certificate has been signed by led in by the funeral director, page 2 should be deaa	Certification:	1 X Natural 5 Pendi	28a. Date of Inju (Month, Day,Y		Time of Injury	28c. Injury	s 2 No	26d. Describe	how injury occur	red	
IVISION Our Attend after death. Director:	cati	2 Accident Invest	igation	iurv - At home	farm, street, factor			28f Location	Street and Numi	ber or Rural Route Num	her City
Divi	늹	deterr	not be	july 74 Home,	arm, stroot, rastor	y, 011100 Ball	iding, oto.	or Town,		701 Of Papar House Hairi	Der, City
Division of Vital the Hospital or Attending Physician: bin 24 hours after death. the Funeral Director: After this certifupletely filled in by the funeral director.		20a Certifier	vsician: To the best of m	y knowledae. de	eath occurred at th	e time, date	and place.	and due to the cau	se(s) and manne	er as stated.	
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certification at hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	(and any	niner:On the basis of examiner and manner stated.								
To To Con	₽ B	29b. Signature and title of certifier	and mainer stated.		29	lc. License i	number	· · · · · · · · · · · · · · · · · · ·	29d. Date sign	ned (Month, Day, Year)	
		Josha H	eed Mp			O.C.M	.E.		April 25, 2	.007	
		30. Name and address of person v	vho completed cause of d								
		Tasha Greenberg MD.	Assistant Medica		111 Penn :	Street, B	altimore,	MD 21201			
Sta Regist	ate	31. Date filed (Month, Day, Year)	2007 32. Registra	r's Signature	South	1					
Regist	E.	11171 -									

Physician /Medical **Examiner** The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 s Department of Health ar Important; If Item 27 Is any Injury or other trau

Funeral

Director

r 28a-f show

"natural", or Items 23a or

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

23b. Was decedent pregnant in the past 12 menths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. if yes, outcome pripregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	23d. Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
End Stage	e chronic obstructive Airwaydirace	1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknow
Ancemia.		24a. Was an autopsy autopsy prior to completion of cause of
Chronic E	Back Pain	performed? death? 1 Yes 2 No 1 Yes 2 No
25. Was case referred to medical examiner?	26. Place of Death (C	heck only one)
1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1	n (Month, Day Year) Injury Work? M 1 □ Yes 2 □ No	Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not be determined		Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of my knowledge, death occurred at the time, date and place, and miner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	due to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s)

29c. License number

D 50653

EYAN C. SURANA

Deale MD

29d. Date signed (Month, Day, Year)

4-19-2007

Registrar

completely

Medical

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

C.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Deale

APR 2 3 2007

Churchten

32. Registrans Signature

		,	For State Registrar	State of Maryland	-	rtment of F			giene Reg. No.	007	14584
	Physicia /Medic		1. Decedent's Name (First, Middle, Las	st)		Slate	er	2. Date of Dea	Day 15	2007	3. Time of Death 13:49 M
	Examin		4a. Facility Name (If not institution, give The Johns Hopkins	e street and number) Hospital		4b. City, Town, or Balt	imore	City	4c. Cou	nty of Death	
	Funeral Director		216-22-0587	ex XM 2□ F 7. Age (In yrs. las	t birthday). Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		y, Year)	Cour	place (State or Foreign htry) yland
	Maryland -f show ied at	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Prince		Town or Lo	ndywine				1	0d. Inside City Limits 1X Yes 2 □ No
	3a or 28a st be notif	Funeral Director	10e. Street and Number 14002 Baden Wes		Dia	10f. Zip Code 206	1 3		10g. Citizen	of What Cour	ntry?
20	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mentel Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other tran "natural", or items 23a or 28a-f show other tranmatic event, the Medical Examiner must be notified at	by Funera	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1	1			Specify Yes or No rto Rican, etc.)	- 14. F	Race - Americ Black, White,	etc.
1213-003	vithin 72 hou sne. than "natura te Medical E	Completed	15, Decedent's Ec (Specify only highest gra	College (1-4or 5+)	(Give life. L	lent's Usual Occup kind of work done OO NOT use retired	during most of w			f Business/In	_{dustry} Education
מוומ ע	2 should be filed within and Mental Hygiene. is marked other than is anmatic event, the Me	To Be Co	12 17. Father's Name (<i>First, Middle, Last)</i> George)	Slate	ding Su	18. Mother's Na	ame (First, Middle, Δ	Maiden Surr	name)	nme
, mary	d 2 sho th and ?7 is m traum	Ė	19a. Informant's Name/Relationship (Mary D. Slater/	Type. Print) Wife	19b. Mailin	g Address <i>(Street</i> 2 Baden	and Number or F Westwo	od Rd.E	Brandy	wn, State, Zip /Wine	, ^{Code)} 20613 Maryland
Dallimore	permit, Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		20a. Method of Disposition X☐XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	st.	Thor		4/2	Date 21/07	Bader	on - City or To	
0	permit Depar Impor any in		21. Signature of fulleral Service Liber	19	1 20		asco F		sco, N	l Home	PA and 20608 Approximate
	Physician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line. PSULOMONA Due to (or as a conseque	s Pr	eumonia	ig, such as cardi	ac or respiratory a	rrest,		Interval Between Onset and Death / D days
	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b							
,0070	icate be executed physician and s the burial-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a conseque	nce of):						
O. Box oc	The law requires that the death certifica ate has been signed by the attending proage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnand 1 □ Live birth 2 □ Fetal d 4 □ Pregnant at time of dea	eath 3	Ectopic pregnanc	у		23d.	Date of deliv Month	ery Day Year
ecords, P.	quires that in signed by uld be detail	þ	Part II. Other significant conditions	contributing to death but not result	ing in the u	nderlying cause giv	ren in Part I.				he cause of death?
neco	The law re ate has bee page 2 sho	Completed						24a. Was autoj perfo 1∐ Yes		tb. Were auto prior to co death? 1 ☐ Yes	opsy findings available mpletion of cause of
	sician certificirector	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: 1 X Inpatient 2 ☐ EI	2/Outpation	t 3 DOA Oth	or:	eath <i>(Check only c</i> Home 5 ☐ Resi		045 (0	4.1
0	ng Phy fter this neral d	n: To	27. Manner of Death 1 Natural 5 □ Pending		8b. Time of			28d. Describe			19)
DIVISION OF	or Attendie fter death. Director: A in by the fu	Certification:	2 Accident Investigation 3 Suicide 6 Could not b 4 Homicide determined	e 29a Place of Injury At hom	e, farm, str		Yes 2 No	28f. Location (City or Too	Street and Nu wn, State)	umber or Run	al Route Number,
ב	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical Ce		nysician: To the best of my knowl miner: On the basis of examinatio and manner stated,							
	To the within To the comple	Me	29b. Signature and title of certifier	Al - b I -		29c. Licens				gned (Month,	
	`		Jesse Kim,				S-000		Apri	1 15	, 2007
	DB.ID		Jesse Kim No John	s Hopkins Hospital, 6	00 No	orth Wolfe	street,	Baltimore,	Maryla	nd i	21287
	Sta	ate	31. Date filed (Month, Day, Year)	32. egistrar's Signatu	TP.	met 1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** chulze 45 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Columbia Howard Howard County General Hospital 5. Social Security Number 6. Sex 7. Age (In yrs yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**∑**M 2□F New York 84 Yrs. Director 090 16 6163 Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits 28a-f show : If item 27 is marked other than "natural", or items 23a or 28a-f si or other traumatic event, the Medical Examiner must be notified 1 Yes 2 No **Funeral Director** MD Howard Highland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 3 13426 Good Times Ct. USA 20777 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰ Yes 2 □ No 1942— If Yes, Give Year or Dates: 1945 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Owner Restaurant Franchise 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Carl Schulze Dorothy VanVliet ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John F. Schulze/son 4230 Buckskin Lake Dr. Ellicott City, MD 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4/24/2007 Metro Crematory Catonsville, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signatu of Funeral Service Licenses M01442 evonice 4112 Old Columbia Pk. Ellicott City, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lige. Approximate Interval Between Opset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Se juentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify). 1 ☐ Yes 2 ☐ No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1∏ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 No Other: ၉ 1 ☐ Yes 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? I Director: After the in by the funeral 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 Tyes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral C completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year)

Registrar

31. Date filed (Month, Day, Year) State APR 2 DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KWY

CARMEN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death APRIL. Pay, **Physician** 2007 04:50F M Melvin Eric Santmyer /Medical 4a. Facility Name (If not institution, give street and number, Saint Joseph Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Center Baltimore Towson If Under 24 Hrs. Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year **Funeral** Days Hours Min 1XIM 2∏ F Oct 21, 1954 Maryland Director 217 56 3117 52 Usual Residence of Decedent death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 23a or 28a-f show notified at 1 TYes 2 XNo Director MD Howard Columbia 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number traumatic event, the Medical Examiner must be 21046 United States 9693 Gerwig Lane Suite T Funeral items 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. Ither than "natural", or ite 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 'natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: 2 White 3 ☐ Widowed 4 € Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Electrical Contractor Self Employed and Mental Hygi 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Nancy Carbaugh Melvin E. Santmyer 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If Item 27 Is any injury or other trau Benjamin E. Santmyer/Son 6414 Rockledge Court Elkridge, MD 21075 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4-21-2007 Catonsville, MD Metro Crematory 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licenses M01044 Shem 4112 Old Columbia Pike Ellicott City, MD 21043 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** PULMONARY EMBOLI disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner MYDCARDIAL INFARCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): physician s the burial Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 npatient 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA ٩ 28a. Date of Injury (Month, Day 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: the Hospital or Attending Natural Accident 5 Pending investigation Injury 1 ☐ Yes 2 🗆 No death. hours after death uneral Director: 3 ☐ Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medica (Check only and manner stated 29b. Signature and title of certifie 29c. License number D46356 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (0)22 TABASSI, 7601_OSLER DRIVE TOWSON. MARYLAND KHOSROW M.D. 31. Date filed (Month, D gistrar's Signature Year State 23 2007 Registrar

			1 - State Amend #10a-f Pe	tate of Marylar Tnf G867	3/10/0	rtment of H	lealth and M Death	Mental Hy	giene Reg. No:		14587
Г	Physic	ian	1. Decedent's Name (First, Middle, Last)					2. Date of De Month 04	Day 13	Year	3. Time of Death
	/Medi	cal	4a. Facility Name (If not institution, give street	inley Strze	Lec	4h City Tourn or	Location of Death			2007	0855 a⁴
100	Exami	ner Så		and mamber)					40.00	ounty of Death	Arundel
*	Funeral Director		Fort Meade 5. Social Security Number 6. Sex 151-42-1321	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir	th ly Year)	9. Birth	nplace (State or Foreign untry) Jersey
104	P.		Usual Residence of Decedent					12,00,		(100	Octoby
	anylar	_	10a. State 10b. County Somerset		ry, Town or Loc		_				10d. Inside City Limits
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	ath with the 123a or 2	Funeral Director	7481 Ridge Rd. 6 Ha	wley Road		10f. Zip Code 210	7 6 0884	4	_	of What Cou USA	untry?
36	ba filed within 72 hours after death with the Maryland that Hygiene. Id other than "natural", or Itema 23a or 28a-f show event, I're Madicel Examinar must be multified at	by Fune	1 Never Married 2 Married	Vas Decedent Ever in U kmed Forces? ☐XYes 2☐No fYes, Give /ear or Dates: 200	If	/as Decedent of Hi Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		Race - Amer Black, White	ican Indian, , etc. nite
8	2 hours		15. Decedent's Education			ent's Usual Occupa	ation		16b Kind	of Business/li	
21215-0036	c * @	Completed	(Specify only highest grade cor	College (1-4or 5+)	(Give k lite. D	ind of work done of O NOT use retired.	turina most of work	king	US A		idustry
10	should ba filed withir nd Mental Hygiene. marked other than imatic event, ITA M	Be Co	17. Father's Name (First, Middle, Last)		301	.u.tet	18. Mother's Nam	e (First, Middle,			
Maryland	d 2 should ba fi h and Mental H 7 is marked ot traumatic ever	To B	Stanley V. Strzelec				Cecilia	Grabows	ski		
a D	0 6 6	•	19a. Informant's Name/Relationship (Type, F	Print)	19b. Mailing	Address (Street a	and Number or Rui	al Route Numbe	er, City or To	own, State, Zi	ip Code)
	5 = N -		Kathleen Strzelec/W				Hillsbor	ough, N.	J. 08	844	
Baltimore,			20a. Method of Disposition 1 🏿 Burial 2 □ Cremation 3 □ Remo 4 □ Donation 5 □ Other (Specify)	-14 Ct-t- C	Place of Dispos Semetery, cremi SUPPECT	ition (Name of atory or other place ion Ceme	9) //2-	Date L/07		ion - City or T taway,	
Balt	permit. Page Department of Important: if any injury or		21. Signature of Funeral Service Licensee	cuplin		Name and Addres	s of Facility 4510 W:	ilson Bl	Lvd. A	rlingt	on, VA 22203
	Physician and //Medical Examiner	al Examiner	23a. Part1. Enter the disease, or complication shock, or heart failure. List only one call immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	use on each line. ypertensive Due to (or as a consequence of the con	Atherouence of):					ease	Approximate Interval Between Onset and Death
P.O. Box 68/60,	the death certi y the attending chad for use a	Physician/Medical	in the past 12 months?	yes, outcome of pregna □Live birth 2 □ Fetal □ Pregnant at time of de □ Unknown	death 3 🗆 E	Ectopic pregnancy Other (specify)			23d.	Date of deliv Month	ery Day Year
		þ	Part II. Dther significant conditions contribu	ting to death but not resu	ulting in the und	derlying cause give	n in Part I.	23e. Did to			he cause of death?
or Vital Records,	The law ate has b page 2 sl	Completed						24a. Was autop perfor	an 24 sy med?	4b. Were auto	opsy findings available impletion of cause of
<u> </u>	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	al.		la:	26. Place of Death	(Check only o	ne)		
on or	ing Phys After this funeral dir	lon; To		a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at ?	me 5 Resid 28d. Describe h			(v)
DIVISION	l or Attending after death. Director: After	Certification	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	e. Place of Injury - At ho building, etc. (Specify	me, farm, stree		es 2 No	28f. Location (S City or Tow	itreet and Ni n, State)	umber or Run	al Route Number,
_	Hospita 4 hours Funarai ely fillec	edical Ce	29a. Certifier Cortifying Physicier (Check only one) 2 Medical Exeminer:	on the basis of examinat	wledge, death o	occurred at the time stigation, in my opi	e, date and place, inion, death occurr	and due to the d	ause(s) and	manner as s	stated. to the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier	nd manner stated.		29c. License				gned (Month,	
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,	2		30. Name and address of person who comple	ted cause of death (Item	23a) (Type, Pr		220UA	IN	04	16	2007
	2/		Sean Swiatkowski	8901 Wiscon	nsin Av		ethesda,	MD 208	889		
	Sta Registr	99	APR 2 0 2007	32. Registrar's Signa	iles						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 = State Registrar Amend#27.PerPhys.PC4-20-07cr Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** Month Year 4:00 P M Joseph A. Sealey, Sr. April 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Southern Maryland Hospital Clinton Prince George's If Under 1 Year If Under 24 Hrs
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 110 M 2□ F Director 89 252-22-1612 May 10, 1917 Georgia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Exaπiner must be notifled at TY_Yes 2 No Directo Maryland Prince George's Suitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1806 Campbell Drive 20746 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1X Yes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 African 1 ☐ Yes 21 No Specify: Completed by 3 ☑ Widowed 4 ☐ Divorced Year or Dates: American 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sup. Mail Room Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked George M. Sealey, Sr. ပ Beatrice Reynolds 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dolores C. Kemp/Daughter 11401 Hershey Red Pl., Clinton, MD 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Lincoln Memorial Cem. 4/19/2007 Suitland, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., NE Wash., DC 20019 23a. Part1. En et the disease, or complications that caused the shock, or he, it failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cau le (Final disease or condition n resulting in death Meumon **Physician** in Knos. /Medical Due to (or as a con sequence of) Examiner ordiom Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ 📈 б 1 Inpatient ပ 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Natural endina ours after death.

neral Director: A
filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

ompletely State Registrar

DHMH 17 Rev 1/2001

(Check only one)

29b. Signature and title of certifier

Name and address of pers

31. Date filed (Month, Day, Year)

-41

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signa

Ave

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29c. License number

Arastoo Yazdani,

29d. Date signed (Month, Day, Year)

M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

17. 18 per 1h 8807 5-8-07 vt.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First Middle Last) Day Month Vear APR 14 2007 9:00 P M ADRIAN F. SCOTT 4c. County of Death 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) MONTGOMERY NATIONAL NAVAL MEDICAL CENTER BETHESDA 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 1XM 2□ F Months 212-98-4384 Washington DC 41 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10b. County Oxon Hill 1X Yes 2 No Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 310 Brockton Road 20745 United States Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Chef 12 4 Private Mother's Name (First, Middle, Malden Sumame)
Rose Marie Francis
Rose Washington Rose Rose 17. Father's Name (First, Middle, Last) Robert Bernard Scott Bernard Scott 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Steve Avery/Friend 310 Brockton Road, Oxon Hill, Maryland 20745 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Metropolitan Crematory 4/18/07 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 5538 Marlboro Pike 21. Signature of Funeral Service Licens Pope Funeral Homes, P.A. Forestville, MD 20747 01085 Approximate Interval Between Onset and Death Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPSIS

Physician /Medical Examiner

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after death. Director: Af

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director,

filled in by

The law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

the Hospital or Attending Physicien:

Examiner

Physician/Medical

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Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of) AIDS Due to (or as a consequence of):

Due to (or as a consequence of):

IF FEMALE

1 - For State Registrar

10a. State

Physician

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Funeral

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items 23a death v

"natural", or

Pages 1 and 2 should be filed within 72 f nent of Health and Mental Hygiene. int: If item 27 is marked other than "hati

or other treumatic event,

the Medical Examiner must be notified at

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Completed

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Baltimore, Maryland 21215-0036

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 🗆 Unknown

25. Was case referred to medical

5 Pending

investigation

6 Could not be determined

1 Yes 2 No

examiner'

27. Manner of Death

1 XNatural

2 Accident 3 ☐ Suicide

4 Homicide

29a Certifier

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death

4 Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Day Month

23e. Did tobacco use contribute to the cause of death?

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. Date of Injury (Month, Day Year)

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1□ Yes 2√ No

1 ☐ Yes 2X No

26. Pface of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

281. Location (Street and Number or Rural Route Number, City or Town, State)

1 X Cartifying Physician: To the best of my knowledge duath accorded at the time. Jate and place, and due to the cause(s) and more as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

Infury

29d. Date signed (Month, Day, Year) 16746 (OR) APR 16 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NATIONAL NAVAL MEDICAL CENTER BFTHESDA MD 20889-5600

State Registrar

LCDR LEE W. VANCE MC USN 31. Date filed (Morith, Day, Year) APR 2 0 2007 32. Registrar's Signatur

			For State	State	of Marylar		rtment of F		d Mental Hy	0.0		11590
4			Registrar 1. Decedent's Name (First, Middle,	Last)		007	inicate or	Dean	2. Date of D	Reg. No.	121	3. Time of Death
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	Examin	100	4a. Facility Name (If not institution,		•		4b. City, Town, o		eath	4c. County		
· ·			Southern Maryl	and Hos	pital 7. Age (In yrs.	(a ct hirthday)	Clinton If Under 1 Year		Hrs. 8 Date of Bi	Prine	ce Ge	orge's
	uneral irector		5. Social Security Number 577-46-7389	1 □ M 2 X F	72	Yrs.	Months Days		lin. (Month, D	rth 1935 ay, Year) ary 8	Chat	tanooga TN
pu	>		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	cation					0d. Inside City Limits
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the N	28a-1 notifi	Director	Maryland Prince 10e. Street and Number	George s	5 5	Suitlan	10f. Zip Code			10g. Citizen of	What Cour	ntry?
with	3a or st be	Ö	3715 Leeds Driv	re			20746	ó		United	d Sta	tes
death	rmus 2	Funeral	11. Marital Status	γ	cedent Ever in U	J.S. 13. V	Vas Decedent of H f Yes, specify Cub	lispanic Origin?	? (Specify Yes or N		ce - Americ	
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shou	s mar umati	۲	19a. Informant's Name/Relationship	p (Type. Print)		19b. Mailin	g Address (Street	and Number o	r Rural Route Num	ber, City or Town	, State, Zip	Code)
and 2	27 is er tra		Calvin Walter	Sample,	/Son	3715	Leeds Di	cive, S	uitland,	Maryland	1 207	46
es 1	f item or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	3 □Removal from	m Ctoto	cemetery, crer	sition (Name of natory or other pla	ce)	Date	20c. Location	-	
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The	cate h	Con							per 1□ Yes	formed? 2 No	death? 1 ☐ Yes	2 🕱 No
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Physi	this cral din	T0	1 ☐ Yes 2 ☑ No 27. Manner of Death	. 10	☑Inpatient 2 ☐ te of Injury	ER/Outpatier	IL 3 DOA		ng Home 5 ☐ Res	sidence 6 Ot		fy)
ding -	After funer	tion	1 Natural 5 Pending 2 Accident investiga	(Mo	onth, Day Year)	Injury	Wo	rk?]Yes 2∐No		non injury occu		
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Hospi	within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Medical		xaminer: On the					place, and due to th occurred at the time			
o the	Vitriin Fo the comple	Me	29b. Signature and title of certifier				29c. Licens			29d. Date sign	ed (Month,	Day, Year)
-			> Raitur For	h_ /	M.D.		104	344 6		4.17.	07	
R	(10)		30. Name and address of person w	/ho completed ca	use of death (Ite	em 23a) (Type,	Print)	uit 7-	41 Silva	Sprino	MO	20902
	Sta	ate	RUNTAN FARAH 1 31. Date filed (Manth, Day, Year)	32.	Registrar's Sign	nature	- October	. 4	., -,,,,,,			
	Regist		APR 2 0 2007	Figure) A.	Speck	,					

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Day 1806 April 2007 James M. Shuler 18, 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Peninsula Regional Medical NIOMICO Salisburg centu If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 12¥M 2□F 221-26-0075 65 April 17, 1942 Virginia Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Wicomico Delmar 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21875 U.S.A. 29590 Haneys Branch Road 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced white 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Custom Cutting Shop 12 Meat Cutter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Ellen Atwell James Franklin Shuler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Delmar, MD 21875 29590 Haneys Branch Road Virginia Shuler (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Stephens 20a. Method of Disposition Date 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4-22-2007 Delmar, Delaware Cemetery Park

22. Name and Address of Facility 21. Signature of Funeral Service Licensee Short Funeral Home ewe Delmar, DE Grove Street 13 E. Approximate Interval Between Caset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Mon Small all carcinome of Due to (or as a consequence of): Eequeritally liet on differe, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Distur Sindrum adult resuratory Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Dav 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 Yes 2 No 1 Npatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other trau once.

Physician

/Medical

Examiner

Funeral

Director

sa or 28a-f show t be notified at

"natural", or items 23a edical Examiner must t

Medical

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and 2 should be filed within 72 hours after death with 'eaith and Mental Hygiene. n 27 Is marked other than "natural", or items 23a or '

Maryland 21215-0036

Baltimore,

Director

Funeral

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Completed

Be

MD

executed burialphysician death certificate be Physician/Medical the attending for use as the

Examiner

Completed

Be

2

Certification:

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 | Homicide

detached been signed by should be detact this certificate has page 2 After 1 death

Box P.0. Records, or Vital Division Hospital or Attending

within 24 hours after death

To the Funeral Director:
completely filled in by the To the I (it

State

Medical 29b. Signature and title of certifier

5 ☐ Pending investigation

6 Could not be determined

28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28d. Describe how injury occurred

D0014314

29c. License number

29d. Date signed (Month, Day, Year) 419107

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

145 E Stant Conoll Strut, Solisbury, md 2180/ PANPIT P. KLUA.

31. Date filed (Month, Day, 2 0 32. Segistrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Physician 18 2007 5:15 PM M Velda B. Shockley April /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Salisbury Wicomico Wicomico Nursing Home If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 M 2 X F 218-16-6365 84 Director April 10, 1923 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b, County 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Director MD Wicomico Sharptown 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number 201 Church Street 21861 U.S.A. Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 2 should be filed within 72 hours after a nand Mental Hygiene.

Is marked other than "natural", or Itel 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🖾 No Baltimore, Maryland 21215-0036 Specify Specify. þ white 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) school cafeteria cafeteria worker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George F. Bradley Ruth M. Windsor ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any Injury or other tra once. Audrey S. English (daughter) P.O. Box 334 Sharptown, MD 21861 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fireman's Cemetery April 23, 2007 Sharptown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Short Funeral Home ewe Delmar, DE13 E. Grove St. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) END Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the attending ph IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) signed by the a 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ⋛ 4 Unknown 1 Yes 2 No 3 Probably ENERPOVASONI Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an CRASTINESOPHAGEAU certificate has b rector, page 2 s performed 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ Mo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 2 Accident 5 Pending investigation the Funeral Director: Af 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and ittle of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maesha Thimmarayappa M.D. 614 Easternshore Dr Salisbury MD 21804 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#24a per VERB G867, 5/4/07, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) April 26, Day 2007 Year 7:20 PM M Topper F. Joseph 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick Citizens Care and Rehabilitation Center Frederick If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Months Days Hours Min. 03⁴03⁴-193⁶ Perinsylvania 1 → M 2 □ F 162-26-2885 77 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location Frederick County Frederick 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21701 USA 355 Rosemont Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊡Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: white 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Transportation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gertrude E. Wivell Roger F. Topper 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2746 Pumping Station Road Fairfield, Pa. 17320 Donald Topper brother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ,2 Cremation 3 Removal from State St. Mary's Cemetery May 1, 2007 Fairfield, Pennsylvania 5 Other (Specify) 22. Name and Address of Facility Keeney & Basford Funeral Home 106 Fast Church Street Frederick, Maryland 21701 Due to (or as a consequence of) Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy 5 ☐ Other (specify) 4☐Pregnant at time of death 9☐ Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? performed? Yes 2 X No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Funeral

Director

show r 28a-f show notified at

'natural', or items 23a or dical Examiner must be

MD

Director

Funeral

Be Completed by

2

death with the Maryland

Baltimore, Maryland 21215-0036

Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event; the Medical once. 20a. Method of Disposition 1 ☐ Burial 4 □ Donation 21. Signatur f Funeral Service Life Part1. Enter the gisease, or complications that caused the death. Do not enter the mode of dying shock, or heart fullure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine physician a s the burial-Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Be Completed 25. Was case referred to medical examiner? 1 Yes 2 No 2 27. Manner of Death 1 Watural Medical Certification: After death neral Director: / 2 Accident 3 ☐ Suicide 4 Homicide within 24 hours after To the Funeral Dire Mcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 58391 April 27, 2007 completed cause of death (Item 23a) (Type, Print) Sajjed Aziz, M.D., 801 Toll House Ave., C-3, Frederick, Maryland 21701 32. Registrar's Signature 4 2007 31. Date filed (Month.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend line 14 per fd State of Maryland / Department of Health and Mental Hygiene aaco hlth dept 4/19/97 dlw Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 11:15P M 15 2007 April Barbara Tracy /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arunde1 Shady Side 1511 Calloway Dr. If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Feb 23 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 ☐ F Ĩ919 88 Yrs 230-50-5579 Ohio Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County show an "natural", or items 23a or 28a-f shov Medk al Examiner must be notified at 1 ☐ Yes 2 😿 No Shady Side Director Maryland Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20764 1511 Calloway Dr. Funeral 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: Letter black Maryland 21215-0036 1 ☐ Yes 2 ☐ Yo Specify If Yes, Give Year or Dates: \$ 3 ☐ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) C. Public College (1-4or 5+) Elementary/Secondary (0-12) than the School System Educator 5yrs 12th s 1 and 2 should be filed to the Health and Mental Hygic item 27 is marked other other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lizzie Smith William H. Buckner ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5007 Adrian St. Rockville, Md. Andrea Holmes(Daughter) : If item 27 or other t Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Pages 1 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department o Important: If any injury or once, Ft. Lincoln 4-23-07 Brentwood, Md. 4 ☐ Donation 5 ☐ Other (Specify) WanName Reddees of Sacil Sons Mortuary, P.A. 21. Signature of Funeral Service Licenses Zarry H. Rosse MOO 483 | 821 West St. Annapolis,
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 821 West St. Annapolis, Md. 21401 Approximate Interval Between Onset and Death Immediate Cause (Final unknown **Physician** disease or condition resulting in death) /Medical Due to (or as onsequence of): Examiner Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner certificate be executed and Due to (or as a consequence of) burial-1 Box 68760. attending physician Physician/Medical the as IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death use 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 🗷 No for 5 Other (specify) P.0. the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an page 2 s has autopsy 1 Yes 2 No certificate Division or Vital 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3□ DOA 1 Inpatient P 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Certification: After (Month, Day Year) Injury 1 XNatural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death.
To the Funeral Director: A completely filled in by the fu death. 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the pert of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) if magnet stated. 2 ☐ Medical Exam (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mD Riva Rd Suite 112, Annapolis P 2629 21401

State Registrar MD.

Registrar's Signature

mo

31. Date filed (Month, Day, Year) APR 1 9 2007

State of Maryland / Department of Health and Mental Hygiene

		•	1 - State Registrar	,,,	Cer	tificate of L	Death	Re	g. No.	14090
			Decedent's Name (First, Middle, Las	(i)				2. Date of Deat	h	3. Time of Death
	Physicia		Frances 1	Irene Tyson				April 1	15, 2007	1:15 M
į.	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death	·	4c. County of Death	
1			Civista Medical	Center		LaPla			Charles	
	Funeral		Social Security Number 6. Security Number			If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birthp	place (State or Foreign htry)
н	Director	,	213-42-9090	□м 2120 F 63	Yrs.			Jul 14	, 1943 Wa	sh. D.C.
	pur *	-	Usual Residence of Decedent 10a. State 10b. County	10c. City, T	own or Lo	cation			1	Od. Inside City Limits
	•ho	5	MD Charle			e Hall				1 ☐ Yes 2√ No
	the N	Director	10e. Street and Number	Char	1000	10f. Zip Code		10	0g. Citizen of What Cour	
	with a or		7710 Arbor View	Dmirro		2062	n		US	•
	ne 23	Funeral	11. Marital Status	12. Was Decedent Ever in U.S.	13. \	Was Decedent of His f Yes, specify Cuba		ecify Yes or No-	14. Race - Americ	can Indian,
	fter of	F	1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 ☐ Yes 2 ☑ No				Rican, etc.)	Black, White,	
036	urs a	PE P	3 Widowed 4 Divorced	If Yes, Give TY Year or Dates:		1 ☐ Yes 2XX No	Specify:		Specify: Wh	ite
5-0036	72 hours after death with the Maryland Insturet, or Iteme 23s or 28s-f ehow dical Examiner must be notified at	Completed	15. Decedent's Ed (Specify only highest gra		6a. Deced	ient's Usual Occupa	ition	ina	16b. Kind of Business/In	dustry
2121	within ene.	현	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	DO NOT use retired,)			
2	filed wi Hygien ther th	S	9		Admir	nistrativ			Automotive	e
nd	d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam		_	
Х	2 should be filed withir and Mental Hygiene. Ie marked other then eumatic event, the M	10	Stephen L.	Bollo					razee	
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Heelih and Mendal Hygiene. If Item 27 is marked other then "naturel; or iteme 23a or 28a-f show if Item 27 is marked other then "naturel; or item and be notified at or other treumatic event, the Medical Examinar must be notified at	İ	19a. Informant's Name/Relationship (1						City or Town, State, Zip	
	l and leelth		William Tyson (hu			Arbor V10 sition (Name of		Date	tte Hall, M	
Baltimore,	permit. Pages 1 and Department of Heelth Important: if Item 27 any injury or other tr once.		1 🔀 Burial 2 □ Cremation 3 □	Removal from State	etery, cren	natory or other place	e) Apı	20		
ţ	t. Partmer		4 Donation 5 Other (Specify			leterans (Cheltenham	
Bal	permit. Pag Department Important: I any injury o		21. Signeture of Funeral Service Licen Gary J. Goff			3125 South			l Home Calve	ert, PA , MD 20736
			23a. Part1. Enter the disease, or comp							Approximate
			shock, or heart failure. List only immediate Cause (Final	one cause on each line.	<i>(</i>).	N	١	5	/ / 1	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	Pu	1 mon	one	ant	100	
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		e.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequer	ice of):	JUJ CE	0 / 00	-/-	aut	()
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							3
Ć.	The law requires that the death certificate be executed sie has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Exa	resulting in death) Last	Due to (or as a consequer	ice of):				le	EXAMINER
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Вох	eath cer attendir for use	_	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnance		Ectopic pregnancy	Λ		230. Date of deliv	ery
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Division of Vital Records,	or At after of Direct in by	Certification;	4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	s, farm, str	eet, factory, office		City or Town	I I Vall'	al Houte Number,
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	To the Hospital or Attending Physician: The within 24 hours eiter death. To the Funeral Director: After this certificete h completely filled in by the funeral director, page	edicai	(Check only 2 Medical Exam	niner: On the basis of examination and manner stated.	and/or in	vestigation, in my of	pinion, death occur	red at the time, da	ate and place, and due t	o the cause(s)
	o the o the ornole	Me	29b. Signature and title of certifier			29c. License	number	2	9d. Date signed (Month,	
	F s F ŏ) Sanda	(1) were		2	3044		4-19	_0)
	•		30. Name and address of person who	completed cause of death (Item	a) (Type.				, , ,	
	12			525 Greenway Cer			eenbelt.	MD		
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** <u>A</u> M Virginia C Wilde May 2007 1:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 € F 579-26-4068 Director 82 10-20-1924 MD Usual Residence of Deceden permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sh Examiner must be notified 1 ☐ Yes 2 ☑ No Director WVa Jefferson Ferry Harpers 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 84 Hickory Woods Court 25425 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11, Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore. Maryland 21215-0036 1 ☐ Yes 2 ☑ No 3 ☐ Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Legal Secretary Law Office 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hugh F. Cornwell item 27 is marke other traumatic P Glenna Allnutt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hickory Woods Ct Harpers Ferry WVa 25425 Deborah Alston Grd Datr 84 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Important; If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Smithsburg Crem. 5/2/2007 Smithsburg, MD 22. Name and Address of Facility Keeney & Basford P.A. F.H. . Signature of Funeral Service License M01176 106 East Church St. Frederick, MD 21701 lla 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 7 4 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Due to (or as a consequence of) attending physician a for use as the burial-P.O. Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 ☐ Ectopic pregnancy Month 5 ☐ Other (specify) signed by the a □Yes 2□No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of hast autopsy performed? death? te 2 🗆 No or Vital 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ Ne 1. Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation (Month, Day Year) Injury 1 Natural 1 ☐ Yes 2 ☐ No Μ 2 ☐ Accident within 24 hours after death.

To the Funeral Director: completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 PAR Willen 180 T.J. Drive Frederick, MD 21702 31. Date filed (Month, Day, Year) Registrar's Signature State MAY 0 4 200 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2:50 p_M Eric Walter Wolf April 18, 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Montgomery Hebrew Home of Greater Washington Rockville If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Min. Months Days Hours 15 M 2 □ F Yrs. Director 062-16-0452 February 20,1922 Germany 85 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location **ehow** 10b. County 10d. Inside City Limits the Medical Examiner must be notified at 1 Yes 2 No Director Virginia Fairfax Falls Church 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 'natural', or itema 23a 22044 U.S.A. 6300 Waterway Drive death Funera Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. filed within 72 hours after 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: þ Caucasian 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation permit. Pages 1 and 2 should be filed within 7:
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na eny injury or other traumatic event, tha Medic once. (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 5+ Engineer Engineering 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Emilie Kiefer Josef Wolf 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 300 S. Jefferson Street, Arlington, Virginia 22204 Lloyd Wolf - Son 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State King David 4 ☐ Donation 5 ☐ Other (Specify) Memorial Gardens 4/20/2007 Falls Church, Virginia 21. Signature of Funeral Service License 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ASTASES **Physician** /Medical Due to (or as a consequence of): Examiner MELANOMA Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the attending physician and the for use as the buriat-transit Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 4 Pregnant at time of death detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 □ Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? Yes 2 No 1 Yes To the Hospital or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) this After this funeral of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Magner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 2 Accident 5 Pending within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 0018084 T

DHMH 17 Rev 1/2001

State

Registrar

FIVA

gistrar's Signature

MONTROSE RO ROCKVILLE MOZOSOZ

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32.

31. Date filed (Month, Day, Year)

APR 2 0 2007

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	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. It has been so that the matural, or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Director	MD Charle	es	Wald							1 □Yes 2 ½ No
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	ter d	Ē	11. Marital Status 1 ☐ Never Married 2 ☑ Married	Armed Forces?		If Yes, spe	ecify Cuba	n, Mexican, P	? (Specify Yes or uerto Rican, etc.)	NO-	Black, Whit	
036	urs al al', or Exam	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes	2 X No	Specify:			Specify: Wh	ite
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o`	l and lealth im 27		Nancy Whitington	(wife) Whi				on Cou		lorf,		
õ	0 0 = =		20a. Method of Disposition → Burial 2 ☐ Cremation 3 [crematory or	other plac	e) A	pr 24 2007		_ocation - City or	-
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Division or Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicia completely filled in by the funeral director, page 2 should be detached for use as the bur	Physician/Medical	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at 9□Unknown		5 Other (s				-	Month	Day Year
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rds	w requires that been signed to should be deta	d by	1 1		SEASE				1	☐ Yes 2	2) Z .No 3 ☐ Pi	robably 4 Unknown
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	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director; After this certific completely filled in by the funeral director,		29a, Certifier 1 Certifying P	hysician: To the best	of my knowledge.	death occurred	at the tir	ne, date and p	lace, and due to	the cause(s) and manner as	s stated
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	With Con	Σ	29b. Signature and title of certifier			29	c. Licens			29d. D	ate signed (Mont	th, Day, Year)
			C Gucclarch	_ M.	1).	5:	116	55		14	118/0	1
	10		30. Name and address of person who	22 S. Completed cause of di	eath (Item 23a) (T	ype, Print)	A(T.	Mi) RE	MD	217	201	
	Sta	te	31. Date filed (Month, Day, Year)	22 5. GRE 32. Registra	Signature			0.00)	- 10	- /	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day April 15,2007 150 am ™ Wade Daisey /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Clinton Southern Maryland Hospital If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 M M F 06/12/1935 216-34-0987 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show notified at 1X Yes 2 □ No Director Charles Waldorf Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ms 23a or must be n USA 20613 Funeral 3535 Malcolm Road 27 Is marked other than "natural", or items traumatic event, the Medical Examiner mo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🛣 No Specify: Specify: Black 2 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. s marked other than Spring Delle 12 Bus Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Turner Irene Clarence 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health em 27 I 2208 Elgin Court Waldorf, Maryland 20602 Vanessa Hicks/ Daughter other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H
Important: If ite
any Injury or ot
once. 1X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Marys 4/20/07 Bryantown, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Eugeral Service License 22. Name and Address of Facility Adams Funeral Home PA 20605 Aquasco Rd. Aquasco, Maryland 20608 191 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part1. Ente disease, d shock, or art failure. List Immediate Cause (Final disease or condition resulting in death) Physician 200 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending ph 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4☐Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate has irector, page 2 1□ Yes 2XNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this Date of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation Injury 1 Natural after death.

I Director: A d in by the fu 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not determin 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral Completely filled it 🕱 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical xaminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 2 Medical I the 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar

3 Date filed (Month, Day, Year) APR 23 2007

acques

MD: Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7501 Surratts Roat St. 303 Clinton, Maryland 20735

07-03371

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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5		Pogietrar	Date of Death Time of Death
Physicia		Decedent's Name (First, Middle,Last)	Month Day Year 0619 hrs May 3, 2007
ʻxamii		Gregory Lynden Auffarth 4b. City, Town, or L	ocation of Death 4c. County of Death
		4a. Facility Name (if not institution, give street and humbs)	Prince George's
		Doctors Community Hospital	If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days	Hours Min
Director		220-68-0301 1XM 2F 45 Yrs.	April 20,1962 Country) Maryland
		Have Decidence of Decedent	10d. Inside City Limits
any		10a. State 10b. County 10c. City, Town or Location	1 Yes 2 X No
d d	L	Maryland Paltimore	Essex 10g. Citizen of What Country?
rylan a-fsl	cto	10e. Street and Number	
r Mai r 28	Director	1300 Sugarwood Circle 212	The state of the s
th th 23a notif	ᆵ	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of His	panic Drigin? (Specify Yes or No- , Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
th wi	Funeral	1 Never Married 2 X Married Armed Forces?	
r dea	F.	Yes Zix No	
s afte ral", iner	à	45 Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Decupat	tion (Give kind of work done 16b. Kind of Business/Industry
hour: natu Exan	P P	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	ı
6 n 72 n 72 ical	e	12 Years Route Sales	Stroehman's Bakery
withi iene.	Completed	12 Years ROUTE Sales 17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Malden Surname)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 23 is marked objections in must page 1.8s-f show any important: If remain it is marked objective.	Ις		Joyce Ellen Davis
d be lental arke	o Be	19b, Mailing Address (Street	et and Number or Rural Route Number, City or Town, State, Zip Code)
Shoul shoul nid N is m	Ĕ	Mrs. Donna J. Auffarth (Wife) 1300 Sugarwo	ood Circle Essex, Maryland 21221
nd 2 alth a		20b. Place of Disposition (Name of ce	emetery, Date 20c. Location - City or Town, State
s 1 a of He If ite		4 tz Rurial 2 Cremation 3 Removal from State	Edns. 5/8/2007 Middle River, MD
Page Page nent ant:		4 Donation 5 Other Specify: HOLLY HILL Mem. G	os of Facility
alti mit. partin		21. Signature of Funeral Service Licensee	Funeral Home of Dundalk, Inc.
ന ഉള്ള		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying	g, such as cardiac or respiratory arrest, shock, or heart Between Onset and
sicia		23a Part I. Enter the disease, or complications that caused the death. So well as failure. List only one cause on each line.	Death
edica.		Immediate Cause (Final disease a, Hypertensive Atherosclerotic Carolovasculai Di	Isease
Examine		or condition resulting in death) Due to (or as a consequence of):	
	Н,	Sequentially list conditions, if any leading to immediate Due to (or as a consequence of):	
		if any, leading to immediate Due to (or as a consequence of).	
		if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
50, te be executed iysician and	ransıt	й d	
Sox 68760, death certificate be executed the attending physician and	al - t	UNPENDED AMENDED 23c. If yes, outcome of pregnancy	23d. Date of delivery
50, ite be hysici	e bur	IF FEMALE: 23c. If yes, outcome of pregnancy	3 Ectopic pregnancy Month Day Year
68761 certificate nding phy	as th	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Dther (Specify)	5Cupic programsy
ttend	r use	O Diller (opcomy)	
Box 6876(he death certificate the attending phy	led fo	The in the underlying cause	se given in Part I. 23e. Did tobacco use contribute to the cause of death?
ires that the de signed by the	letacl	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause	1 Yes 2 No 3 Flobably
ires tl	d be		24a. Was an 24b. Were autopsy findings availabl prior to completion of cause of
rds requi	houle		performed? death?
Records, The law requir	ge 2 s	ompleted ———————————————————————————————————	1 ✓ Yes 2 No 1 ✓ Yes 2 No
ision of Vital Records, P.O. Edition of Vital Records, P.O. Editending Physician: The law requires that the redeath.	rector, page	25. Was case referred to medical	ace of Death (Check only one) Dther: Number of Home 5 Residence 6 Other:
Division of Vital tal or Attending Physician: irs after death.	irect	examiner? Hospital: Inpatient 2 ER/Dutpatient 3 DOA	4 Nuising Home 5 Nessesses
Phys er thi	eral di	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c.	Injury at Work? 28d. Describe how injury occurred
n of Iding Pl		To Natural 5 Pending (Month, Day, Teal)	Yes 2 No
Sio Vtten deatl	by th	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office	ce building, etc. 28f. Location (Street and Number or Rural Route Number, Ci or Town, State)
Jor's after	filled in by the	Suicide 6 Could not be determined (Specify)	
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director:	y fille		e, date and place, and due to the cause(s) and manner as stated.
ie 160 n 24 1	letely	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opi	Thor, court
To the within	completely	alle mariner states.	cense number 29d. Date signed (Month, Day. Year)
		29b. Signature and title of certifier	O.C.M.E. May 4, 2007
4		and	
1		30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Balt	timore, MD 21201
H		Ana Rubib Mb. Acolotain me	
	Si	tate 31. Date filed (Month, Day, Year) 32. Registrar's Signature	
D.		trar MAY 0 7 2007 /2000 20 19	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month ()4 **Physician** Barbara 2007 Gale Armentrout /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Kosedale are If Under 1 Year | If Under 24 Hrs. 7. Age (Ih yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Year) 1 □ M 2 € M 52 217-56-8233 30,1954 Maryland Director April Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1 Yes 2 No Director Maryland Baltimore Dunda1k 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code must be r 3701 North Point Road #32A 21222 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? Race - American Indian. 11. Marital Status Black, White, etc. 1 □ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married ō 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 Divorced White 'natural". Completed 15. Decedent's Education (Specify only highest grade completed) 27 is marked other than "natu er traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 Years College (1-4or 5+) とととして とんない Homemaker Own Home 17. Father's Name (First, Middle, Last) Ukn. 18. Mother's Name (First, Middle, Maiden Surname) Be Viola Morris 2 19a. Informant's Name/Relationship (Type. Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tr once. William Kenneth Armentrout 3701 North Point Road #32A Dundalk, MD 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Middle River, MD 4 Donation 5 Dother (Specify) Holly Hill Mem. Gdns. 22. Name and Address of Facility 5/1/2007 21. Signature of Funeral Service Licensee Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner monia Sequentially list conditions, and leading to mm. leat cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last e to for as a consiquence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the furted director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an s certificate has b lirector, page 2 s autopsy performe 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient ٩ 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State

Registrar

31. Date filed (Month, Day, Year) MAY 0 7

29b. Signature and title of certifier

U

2007

30. Name and address of person what ompleted cause of death (Item 23a) (Type, Print)

RES 0000

29c. License number

29d. Date signed (Month, Day, Year)

n Square

			State of Marylar Phy G867 570	07/Depa Cer	rtment of tificate of	Health and I Death		ne 2 0 0 7			
Physici /Medic		1. Decedent's Name (First, Middle, Last)	A Peter	Alber	't		2. Date of Death Month	Day Year	3. Time of Death P		
Examir	er	4a. Facility Name (If not institution, give s Good Samaritan Nursing			*	or Location of Death altimore		4c. County of Deal	th		
Funeral Director		5. Social Security Number 6. Sex 1(2)	M OFF	last birthday). 98 Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, Yea 09/29/1908	9. Birt Co In	hplace (State or Foreign buntry) diana		
faryland show	٥٢	Usuel Residence of Decedent 10a. State 10b. County Marvland Baltin		ty, Town or Lo					10d. Inside City Limits 1 Yes 2 XNo		
vith the h	Director	10e. Street and Number		Nottir	10f. Zip Code		10g. (Citizen of What Co	puntry?		
permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show apply injury or other traumatic avant, Its Madical Exertinal must be notified at another.	Funeral		Not. A-1 12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ∑No	l I	Vas Decedent of Yes, specify Cul	236 Hispanic Origin? (S ban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	U.S.A. 14. Race - Ame Black, Whit	e, etc.		
d within 72 hours afl giene. er then "natural; or the Medical Exerti	ted by	3 Widowed 4 □ Divorced 15. Decedent's Educ (Specify only highest grade	If Yes, Give Year or Dates:	16a. Deced	lent's Usual Occu		ting 16b.	Specify: Kind of Business	White Undustry		
ed within 7 ygiene. ver than "r t, it e M. of	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	Manufactu	re		Tire Indu	stry		
od 2 should be file th and Mental Hy 27 is marked oth	To Be	17. Father's Name (First, Middle, Last) Peter Albert	2,114,114				ne (First, Middle, Maid Vonnast	en Sumame)			
and 2 sho ealth and m 27 is m		19a. Informant's Name/Relationship (Ty) Edna Bitzelberger - Gua	rdian/Sister	3829 F	. Joopa R		ral Route Number, Cit -1 Nottingh	am, MD 212	36		
Demit. Pages 1 ar Depertment of Hea Important: if Itam any injury or othe		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State Bal	timore C		05/01	/2007 Bal	Location - City or Ltimore, Ma			
permit Deper Impor		21. Signature of Funeral Service License Charles J. Min	ies fr.	L		Ruck, Inc.	5305 Harford Baltimore, M		214		
hysician		23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition	e cause on each line.	th. Do not ente		ing, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death		
/Medical Examiner		resulting in death) Sequentially list conditions,	Due to (or as a consec								
recuted and t-transit	Examiner	Sequentially list conditions, frany leading to infrincefalte cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		8							
ficate be executed physicien and sthe burial-transit	dicai	d									
The law requires that the death certification is a second to the law requires that the death certification is a second be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnation 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of 0 9 □ Unknown	aldeath 3 🗆	Ectopic pregnand Other (specify)	су		23d. Date of del Month	livery Day Year		
quires that a signed by	٥	Part II. Other significant conditions con	tributing to death but not res	sulting in the ur	nderlying cause g	iven in Part I.	23e. Did tobacc		the cause of death?		
	Completed						24a. Was an autopsy performed 1 Yes 2 1	prior to death?	utopsy findings available completion of cause of		
Physician: The This certificate hir ral director, page	Be	25. Was case referred □ medical examiner? 1 ☐ Yes 2 ☑ No	ospital:] ER/Outpatien	t 3 DOA	han 1	ath <i>(Ch</i> ec <i>k only one)</i> Iome 5 ☐ Residence	€ □Other (See	orbe)		
Attending Physic death.	ation: To	27. Manner Death 1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju		28d. Describe how in		city		
To the Hospital or Attending in within 24 hours after death. To the Funeral Director: After crimpletely illed in by the funeral	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special		eet, factory, office	•	28f. Location (Street City or Town, St	and Number or Ri ate)	ural Route Number,		
No the Hospital	Medical	29a. Certifier 1 Certi ying Physical (Check only one) 2 Medical Examination	rician: To the best of my kinder: On the basis of examination and manner stated.	owledge, death ation and/or inv	restigation, in my	time data and plane opinion, death occu	and die 15 the cause irred at the time, date a	(s) and manner as and place, and due	stated to the cause(s)		
To the state of th	M	29b. Signature and title of certifier			29c. Licer	ase number	29d. (Date signed (Mont	h, Day, Year)		
5		30. Name and address of person to co	mpleted cause of death (Ite	m 23a) (Type,	Print) Ron	ien Bi	wd. MD	Baltyn	mne. 21239		
Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	and a						

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	Funeral		5. Social Security N	Number	. Sex	7. A	ge (In yrs. la	st birthd				8. Date of Birt	h(MM/D	D/YYYY) 9. Bi	rthplace (State or
	Director	- 1.	220-9 -	0293	1 1/M	2 F	25		Yrs. Mont	hs Days Hours	Min.	07/03/	198		puntry) MD
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	nours a	å[15. Decedent's E		fy only hi	ghest grade co		16a. De du	cedent's Usua ring most of w	I Occupation (Give orking life. DO NOT	kind of wo	ork done ed)	16b. Ki	ind of Business	/Industry
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	OOC withi giene.	E .	17. Father's Name	(First, Middle,	_ast)			/	-00d S	Bervice 18.Mother	r's Name (First, Middle, N	Maiden S		N30
	215. tal Hy ked of	Be	Alston.	- 4	1					Cyn	thiz	Anr	2 B	eker	
	MD 21215-0036 d 2 should be filed within 7 thth and Mental Hygiene. n 27 is marked other than numatic event, the Medica	2	19a. Informant's N	ame/Relationsh	ip (Type,	Print)		19b.	Mailing Addres	ss (Street an Nun		ural Route Num	ber, Cit	y or Town, Stat	e, Zip Code)
	MD d 2 sh Ith an a 27 i			Baker	Siste	ex	T áoir F	40		ly Drive	Bel	timore,		31117 ocation - City o	r Town State
	or trz		20a. Method of Dis		3 F	Removal from S			Disposition (Na y or other plac	ame of cemetery, e)		Date	200. L	J	Town, State
	Page Page ment c		4 Donation	Other Sp	ecify:		MU	unt	Zion (5-07	Du	indalk	· mo
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of	uneral Service	icensee	stor			22. Name an	d Address of Focilit	PIG	dip A.	Wes	Ther for	
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	o, e be e ysicia	an/Medical	IF FEMALE:			23c. If yes, outc	ome of pred	nancy					230	I. Date of delive	ery
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	n of Vi ding Physi After this funeral dir	٦	27. Manner of De		_	28a. Date of I (Month Da Apr 28, 200	njury v.Year)	1	ime of Injury	28c. Injury at Wor	rk?	28d. Describe Subject sho			
	on eath. or: A	ţi.	1 Natural 2 Accident	5 Pend	ling stigation	Apř 28, 200	37 ,	0013	hrs	1 Yes 2 ₩	No				
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	he Ho in 24 h he Fur		29a. Certifier 1 (Check only one)	Certifying P Medical Exa	nysician: miner:Or	To the best of the basis of e	my knowled xamination a	lge, dea and/or in	th occurred at vestigation, in	the time, date and p my opinion, death o	olace, and occurred a	due to the cau t the time, date	se(s) an and pla	id manner as si ace, and due to	ated. the cause(s)
	To the vithing To the company	Medical	296. Signature a		an	id manner state	ed.			29c. License numbe					Month, Day, Year)
			17 7	. 7	0-	μ				O.C.M.E.			Apr	il 28, 2007	
	1		30. Name and ad	dress of person	who com	pleted cause of	of death (Iten	n 23a)							
	5		Laron Loc			nt Medical E	xaminer	111	Penn Stre	et, Baltimore, I	MD 212	01			
		State		onth, Day, Year)	7 200	32. Regis	trar's Signat	ure	Sparke	P					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Manyland / Department of Health and Mental Hygiene. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 02, 0642 2007 tattie 1)ean May /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore Good Samaritan HOSPITA If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, Month, Day, 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Year) 19 3 1 ☐ M 2 € F 230 46 25/6 NC 30 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "natural", or items 23a or 28a-f ehow the Medical Examiner must be notified at 1 Yes 2 No Funeral Director Galtimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? hoad 13 A 6300 Tramore 21214 death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or ite eny injury or other traumatic event. The Maylland Exemina-1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: δ Specify: 3 Widowed 4 □ Divorced Black Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Duty 12 Hesith Care Nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be D. Sessoms Pearleaner Mitchell James 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Bunch 20a. Method of Disposition Tramore Road Baltimore MD 6300 21214 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) emorial Rock 5/5/07 Baitmore, MD 22. Name and Address of Facility Philip A. Westherford Funeral Services King Memorial Park 21. Signature of Furleral Service Licensee me 10 2431 East Oliver St. BZItimore, MD 21213 23a. Part1. Enter the disease, or complications that guised the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Kespiratory **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sclerosi S L myotrophi Due to (y as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physiclan/Medical Examiner The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 🗀 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Donknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 🗆 No 2 PNo 1 Yes 1 Yes To the Hospital or Attending Physician: the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 PER/Outpatient 3 DOA မှ this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 🗀 Pending Injury 1 ☐ Yes 2 ☐ No death. 2 Accident investigation Director within 24 hours after dea To the Funeral Director completely filled in by th 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier May ed cause of death (Item 23a) (Type, Print) 30. Name and address of person who complete Kathleen Loch ee 5601 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

		•	1 - State Amend #31 Po	SIDAL GOOV	570770E3	tificate of L	Death	Reg	2. U U / g. No.	14500
			1. Decedent's Name (First, Middle, Las	it)		A		2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Mary Frances B1	ubaugh				April 21		12:30 AM
	Examin		4a. Facility Name (If not institution, give	street and number)	-	4b. City, Town, or	Location of Death		4c. County of Death	
			Allegany Nursin	g Home		Cumber1			Allegany	
	Funeral		Social Security Number 6. S	9x 7. Age □M 2∏F	e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9. Birthp	lace (State or Foreign
н	Director		210-24-0030	TW ZWI	77 Yrs.			Dec 24,	1929 Mar	yland
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation	<u> </u>			Od. Inside City Limits
	sho	ō	MD Allega	anv	Cumber					1 ☐ Yes 2 ☐ No
	28a-f	Director	10e. Street and Number		Comper	10f. Zip Code		100	g. Citizen of What Cour	
	a or			_				, ,	g. Onizon or white cour	my:
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	iter d	Funeral	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🕅	No I	Was Decedent of Hi f Yes, specify Cubar	n, Mexican, Puerto	Rican, etc.)	Black, White,	etc.
336	lrs a	by	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 21X No	Specify:		Specify: whi	te
21215-0036	within 72 hours after death with the Maryland jiene. rithan "natural", or Itams 23a or 28a-f show	Completed	15. Decedent's Ed	lucation	16a. Deced	dent's Usual Occupa kind of work done o DO NOT use retired,	ation	11	3b. Kind of Business/In	dustry unk
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p		Be (17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, Ma	aiden Sumame)	
<u>la</u>		To	Cecil Ellis Been	ıan			Eva An	na Fazen	baker	
Maryland	and and Is m	1	19a. Informant's Name/Relationship (7	*		ng Address (Street a	ind Number or Rura	Il Route Number,	City or Town, State, Zip	Code)
	C = 01 L		Kimberly L. Bluba	ugh/daugh	The second secon	2 Bowlin	Street	Cumberla	nd, MD 215	i02
Baltimore,	r in		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☒ Donation 5 ☐ Other (Specify	Removal from State	20b. Place of Dispo cemetery, crer	isition (Name of matory or other place		Pate 20	Oc. Location - City or To	own, State
Balti	permit. Pag Department Important: I any injury o		21. Signature of Funera) Service Licen	Wade Wire	ector St	Name and Addres ate Anato altimore,	ony Board MD 2120	655 W.	Baltimore S	treet
			23a. Part1. Enter the disease, or confi	olications that caused	the death. Do not ent				t,	Approximate
			shock, or heart failure. List only Immediate Cause (Final				***			Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Office to (or as	a consequence of):	1 RUCIN	18 LUN	DI VI) TAJE	DHE YEK
	Examiner			•	a consequence or,					
		ē	Sequentially list conditions, if any, leading to introduct cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequence of):					
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Ó	exec an an rial-tr	Еха	resulting in death) Last	Due to (or as	a consequence of):					
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	tifical ig phy as th									
Вох	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		Ectopic pregnancy			23d. Date of delive	,
	deat	Sicla	in the past 12 months? 1 ☐ Yes 2 💆 No	4☐Pregnant at		Other (specify)			Month	Day Year
P.0	at the de by the a tached	hys	9 Unknown	9 OTKIOWI						
	es tha igned be det	by F	Part II. Other significant conditions of	ontributing to death be	ut not resulting in the u	nderlying cause give	n in Part I.	23e. Did toba	cco use contribute to the	
g	w require been si should b							1 🗆 Yes	2 No 3 Prob	ably 4 Unknown
000	law re as be 2 sho	Completed						24a. Was an autopsy	24b. Were auto	psy findings available mpletion of cause of
æ	The I	mo.						performe		
Vital Records,	ician: T certifical ector, p	Be C	25. Was case referred to medical				26. Place of Death			
	ly s	TOE	examiner? 1 ☐ Yes 25 No	Hospital: 1 ☐ Inpatie	ent 2 ER/Outpatier	t 3 DOA Othe	ar: 4 Wursing Hor	me 5□Residen	ce 6 Other (Specif	y)
υot	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injur (Month, Day	ry 28b. Time of Injury	28c. Injury Work		28d. Describe how	injury occurred	
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.03			3 Suicide 6 Could not be determined	28e. Place of Inju	ury - At home, farm, str c. (Specify)	eet, factory, office		28f. Location (Stre City or Town,	et and Number or Rura State)	I Route Number,
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Division	tal or Atta	Certification:	4 Homicide	building, et						
Div	Hospital or Atta 14 hours after de: Funaral Directo tely filled in by th		29a. Certifier (Check only 2 Medical Exam	ysician: To the best on the basis of	f examination and/or in	n occurred at the tim vestigation, in my op	e, date and place, sinion, death occurr	and due to the cau	ise(s) and manner as s e and place, and due to	tated. the cause(s)
Div	o the Hospital or Atta thin 24 hours after der tha Funaral Directo mpletely filled in by th	Medical Certific	29a. Certifier 1 Certifying Ph (Check only one)	ysician: To the best	f examination and/or in	n occurred at the time vestigation, in my op	inion, death occurr	ed at the time, dat	ise(s) and manner as so and place, and due to d. Date signed (Month,	the cause(s)
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			1 - For State Registrar	State of Man			lealth and I	Mental Hygi	•	14.607	
	Physici /Medic Examir	cal	Decedent's Name (First, Middle, Last, Charlotte M. Bech Bacility Name (If not institution, give	tel		4b. City, Town, o	r Location of Death	2. Date of Death Month April 26	Day Year 2007	3. Time of Death 7:30 AM M	
	Funeral Director		1 Sandy Cove Cour 5. Social Security Number 6. Sec. 15. 216–16–4457		n yrs. last birthday) 84 Yrs.	Balti If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) Mar 30,	Baltimor Year) 9. Birth Con 1923 Mar	re place (State or Foreign intry) yland	
	th the Maryland or 28a-f ehow e notified at	Olrector	Usual Residence of Decedent		Oc. City, Town or Lo	Ltimore 10f. Zip Code			g. Citizen of What Cou	10d. Inside City Limits 1 ☐ Yes 2 ☐ No	
0000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiane. Important: If item 27 ie marked other than "natural", or iteme 23e or 28e-f ehow any figury or other traumatic event, the Madical Examinar must be notified at once.	ed by Funeral Director	1 Sandy Cove Cour 11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates:	1	Was Decedent of H f Yes, specify Cuba I □ Yes 2√√2 No	Specify:	Specify:		ite	
Maryland 21215-0036	be filed within 72 ital Hygiane. d other than "nat svent, in a Madei	Be Completed	17. Father's Name (First, Middle, Last)	College (1-4or 5+)	16a. Deced (Give life. L	lent's Usual Occup kind of work done OO NOT use retired	during most of wor 1) 18. Mother's Nan	ne (First, Middle, Ma	Middle, Maiden Sumame)		
	es 1 and 2 should to the little and Ment of Itam 27 le marke rother treumatic	υ	William Glenn Sca 19a. Informant's Name/Relationship (7) Gary Bechtel/son 20a. Method of Disposition pe, Print)	1 Sa 20b. Place of Dispos	andy Cove	Court B	altimore,	City or Town, State, Z			
Baltimore,	pe mit. Pages Department of Important: If its any Injury or o		1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 21. Signature of Fineral Service Licens	ade, Direc	tor St	Name and Addre ate Anato	ss of Facility Omy Board MD 2120)1	Baltimore	Street	
	Physician /Medical Examiner		23a. Part1. Enter the disease, of combine shock, or the art failure. List only of Immediate Cause (Final disease or condition resulting in death)	Due to (or as a c	lent A	or hy the	g, such as cardiac			Approximate Interval Between Druset and Death Miwstes	
,00700	w requires that the death certificate be executed been signed by the attending physicien and should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last	Due to (or as a co							
.O. BOX 0	Attending Physician: The law requires thet the death certifica act death. act death. by the this certificate has been signed by the attanding phy the funeral director, page 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 🖼 No 9 □ Unknown	3c. If yes, outcome of pregnancy 1					23d. Date of delin Month	very Day Year	
. co. co.	w requires thet been signed b should be deta	leted by Pi	Part II. Other significant conditions con		ot resulting in the un	derlying cause give	en in Part I.			bably 4 🗆 Unknown	
אוומו חכוו	iiclan: The lav certificate has rector, page 2 s	Be Completed	25. Was case referred to medical examiner?	lospital:		2 DOA Oth	0.00	autopsy performe 1 Yes 2	ed? death? No 1 ☐ Yes		
DIVISION OF VITAL RECORDS, P.O. BOX	ttending Phys death. stor: After this / the funeral dii	Certification: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	1 ☐ Inpatient 28a. Date of Injury (Month, Day Ye		28c. Injun Work	+ □ Nursing ⊓	28d. Describe how	ce 6 Dther (Special injury occurred left and Number or Rui		
2	To the Hospital or Attending Physician: The within 24 hours effer death. To the Funerel Director: After this certificate h completely filled in by the funeral director, page	Medical Certif	4 Homicide determined	building, etc. (s ner: On the basis of ex and manner stated	Specify) Ny Kinowiadge, death amination and/or inv	conversed at the tro	re, date and place pinion, death occur	City or Town,	State)	MA A	
	To the within To the Comple	We	29b. Signature and title of certifier	AttendiNG	MD h (Item 23a) (Type, I	29c. Licenso	7118		d. Date signed (Month) Apr 27, 20 10 2(2)		
	Sta Registr			MD. 351	s New York	- 1 D-1	Bulh	more M	10 2121	8	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🕦 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Bridge man **Physician** 2007 Ronald /Medical 4c. County of Death 4b. City, Town, or Location of Death-4a. Facility Name (If not institution, give street and number, Examiner N/A 9. Birthplace (State or Foreign If Under 1 Social Security Number (Month, Day, Year) 09-30-1941 Days Hours Min **Funeral** 1 ☑ M 2 □ F Maryland 65 217-36-4022 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" -- " 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2 ☑ No Baltimore Middle River Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21220 U.S.A. 31 Holcumb Court Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. Specify. White 3 ☑ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Trucking Industry Truck Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ethel S. Finnegan Herbert L. Bridgeman ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 31 Holcumb Court Middle River, Maryland 21220 Lisa Burger - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp 05/05/2007 Towson, Maryland 5305 Harford Road 22. Name and Address of Facility 21. Signature of Funeral Servi - Lig harles Leonard J. Ruck, Inc. Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 10avs **Physician** disease or condition resulting in death) Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner physician and s the burial-transit Due to (or as a consequence of) as attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23h Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 Tyes 2 No ed by the a a I Inknown 9 ☐ Unknown signed by to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Completed peen s 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No has certificate 1∐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2□ No 2 ER/Outpatient 3 DOA 2 Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) 3 ☐ Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

Division or Vital Records, P.O. Box 68760,

The law requires that the death certificate be executed

State Registrar 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sibell MD

Keisterstown

29c. License number

037573

29d. Date signed (Month, Day, Year)

21136

1005,5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2007 Jane R. Corbett 4 May /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Hques HOSPITAI 5+ Baltimore N/A If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 M 2 KF 92 08/21/1914 Maryland Director 215-09-8368 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐Yes 2 X No Baltimore Baltimore Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 127 Edgewood Avenue 21228 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ②No If Yes, Give Year or Dates: 14. Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☒ No Baltimore, Maryland 21215-0036 Specify: Specify: White Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) nd Vental Hygiene. marked other than Own Home 12 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be Grace MacCreight Joseph Thompson other traumatic and Is ma 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) L. Pages 1 and the month of Health and 27 ls Joseph K. Corbett, Jr. (Spouse) 127 Edgewood Avenue, Baltimore, Maryland 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any injury or o 1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State 05/07/2007 New Cathedral Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 22. Name and Address of Facility
Hubbard Funeral Home, Inc.
4107 Wilkens Avenue, Baltimore, Maryland 21229 Mark T- Z 23a. Part1. Enter the disease, or commications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final pueumon'a 10 day **Physician** disease or condition resulting in death) /Medical Due o (or as a consequence of): Examiner 5 dai atrial tibrillation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se a consequence of Examiner that the death certificate be executed sician and burial-tran Due to (or as a consequence of): attending physician for use as the buria P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 🕱 No 9 Unknown cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an Was autopsy performed? After this certificate has 1□ Yes Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No 1 XInpatient 2 ER/Outpatient 3 DOA 1 🗌 Yes P Division or in by the funeral 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: (Month, Day Year) Injury 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide completely filled 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 05/04/200 D585

Registrar

State

d

Jane

Avenue

Caton

900

Registrar's Signature

Baltimore

MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

2007

Tao

07

Lynn

31. Date filed (Month, Day, Year)

		-	For State Registrar	Sta	ate of	Maryland /		rtment of				iene	007	1.6	
			Decedent's Name (First, Michael Control of the	idie, Last)							2. Date of Dear	h Day	Year	3. Time of Death	
	Physicia /Medic		John Albert	Carter							April 2			7:50 AM M	
	Examin	_	4a. Facility Name (If not institut	ion, give street	and num	ber)		4b. City, Town	n, or Location	on of Death		4c. C	County of Deal	th	
			Anne Arundel	Medical Center				Annapo					Anne Arundel		
	Funeral		5. Social Security Number	6. Sex 1)X∫M 2		7. Age (In yrs. last	birthday) Yrs.	If Under 1 Ye Months Da			8. Date of Birth (Month, Day	Year)	Co	thplace (State or Foreign	
	Director		none Usual Residence of Decedent	THE STATE OF THE S			113.			45	Apr 28,	2007	Mar	yland	
	and and		10a. State 10b. Cour	nty		10c. City, T	own or Lo	ation						10d. Inside City Limits	
	Mary 	ţŏ	MD Anne	Arunde	1		Edgev	vater						1 ☐ Yes 2 ☐ No	
	7.28a	Director	10e. Street and Number					10f. Zip Cod	е		1	0g. Citiz	en of What Co	ountry?	
	3a o	D	3418 Spring	Azure	Cour	t			2	1037			USA		
	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Heelth and Mental Hygiene. Department of Heelth and Mental Hygiene. English 21 is marked other than "natural", or items 23s or 28s-f show eny injury or other traumatic event, the Modical Examinar must be notified at ance.	Funeral	11. Marital Status 1 ☑ Never Married 2 ☐ M	arried 1	med For ∐Yes	2 X No					ecify Yes or No- Rican, etc.)		4. Race - Ame Black, Whit	e, etc.	
3	hours a	þ	3 ☐Widowed 4 ☐Divorce	ed If	Yes, Give	ites:	6a. Deced	☐ Yes 2[]	cupation				Specify: W	hite //industry	
017	Aithin 72 ne. han "ne	Completed	(Specify only hig Elementary/Secondary (0-12	hest grade com	ollege (1		(Give life. L	kind of work do OO NOT use re	tired)	nost of work	ring				
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	to be of or	Be	John Albert								Lynn Lov		Jarria III o		
<u> </u>	should nd Men marke umatic	ဥ	19a. Intormant's Name/Relation		nint)		19h Mailin	a Address (Str			ral Route Number		Town State	Zin Code)	
=	d 2 sl th an th an 7 is r traur		Ashley Cart					-			rt Edgev			21037	
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	nit. Pag artment ortant: Injury o		4 □ Donation 5 🕅 Other 21. Signature of Funeral Servina Ld	(Specify) i	n st	ate	C22	. Name and Ad	Idress ot Fa	acility and	655 W.	D 0 1 +	t i m a v a	Ctroot	
Ď	Depa Impo eny is		Lama	3. Wad	MIL	arector		ltimore				рал	LIMOTE	Street	
п			23a. Par 1. Enter the disease shock, or heart failure. I	or complication	is that cause on ea	aused the death. I	Do not ente	er the mode of	dying, such	as cardiac	or respiratory arr	est,		Approximate Interval Between	
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	/Medical		resulting in death)	(a>	Due to (or as a consequen	nce of):		0					110 min	
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	ם ב	Examiner	Sequentially list conditions, it any, loading to immediate cause. Enter Underlying Cause (Disease or injury	1	Due to (or as a sonsequen	ico off:								
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200	phys phys s the	edlcal		d											
ň	death e atter d for u	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 monthe? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 4	Live b	come of pregnancy irth 2 Fetat de ant at time of deati	ath 3	Ectopic pregna Other (specif				2	3d. Date of de Month	olivery Day Year	
Ţ.	that the led by the detache		Part II. Other significant cond	litions contribu	ting to de	ath but not resultin	ng in the u	nderlying cause	given in P	art I.	23e. Did to	bacco us	se contribute t	o the cause of death?	
ras,	requires ween sign hould be	d by									1 🗆 Y	es 2□]No 3 □ P	robably 4 Unknown	
ပ္မ	has b	Completed									24a. Was a autop perfor	sy med?	death?	utopsy findings available completion of cause of	
	ician: Th certificate rector, pag	e Co	25. Was case referred to med	lical					26.0	Place of Deal	1 ☐ Yes th (Check only or	2 No	1 L Yes	s 2 No	
5	Physician: r this certific ral director.	To B	examiner? 1 ☐ Yes 2 No	Hospit	al: 1 U	fipatient 2□ER	VOutpatier	t 3□ DOA	Other		ome 5□Resid		Other (Spe	ecify)	
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DIVISION	after deat Director: I in by the	Certification:		uld not be ermined 28	e. Ptace buildir	of Injury - At home ng, etc. (Specify)	e, tarm, str	eet, factory, of	ice		28t. Location (S City or Tow			lural Route Number,	
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical C		cal Examiner:	On the ba	best of my knowle asis of examination ner stated.									
	To the within 2 To the comple	Ž	296. Signature and title of cer	tifier /	/	00		29c. Li	cense numb	ber		29d. Date	signed (Mon	th, Dey, Year)	
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Angel	a Clarl	k							

ngela Clark		State of Maryland / Department of Health and Mental Hygiene							
Physician	1/	1. Decedent's Name (First, Middle, Last) Argela Clark 2. Date of Death Month Day Year April 30, 2007 3. Time of Death 0658 hrs							
II EXAMININ		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death							
Funeral		3017 Independence Street Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or							
Director	- 1	216-78-7323 1 M 24F 47 Yrs. Months Days Hours Min. Feb. 22, 1960 Foreign Country) Alabamo							
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits							
<u>*</u> .	5	Maryland HA Battimore 1 Yes 2 No 10e. Street and Number 2245 Cecil Arr 10f. Zip Code 10g. Citizen of What Country?							
within 72 hours after death with the Maryland siene. rer than "natural", or items 23a or 28a-f sh. Medical Examiner must be notified at once	Director	10e. Street and Number 2245 Cecil Ave. 10f. Zip Code 10g. Citizen of What Country? USA							
ath with items 23	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Never Married 2 Married 2 Married 2 Married 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.							
after des	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates: 1 Yes 2 No specify: Specify:							
2 hours	eted	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 16b. Kind of Business/Industry							
21215-0036 uld be filed within 72 Mental Hygiene. marked other than	Completed	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)							
21215-00 uld be filed wit Mental Hygien marked other	Be C	Willie Clark Catherine Jackson							
	۵	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod. 2023) Sandeka Stewart daughter 144 W. Battimore St. Battimore Maylan							
. = 2 5 2	f	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date cremation, 3 Removal from State crematory or other place)							
		1 Burial 2 Cremation 3 Removal from State Crematory or other place. 4 Donation 5 Other Specify: 21. Signature of Funegal Service Licenses V22. Name and Address of Facility V22. Name and Address of Facility							
Balt permit. Depart Import injury	ı	Sevin farter 3572 Frederick Are. Battimore, Nd. 2029							
nysician Mulical		23a. Part I. Enter the Visease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Immediate Cause (Final disease a Methadone intoxication and cocaine use							
Examiner		or condition resulting in death) a. Intertraction and cocame use Due to (or as a consequence of):							
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760, cate be physicia	WENDED #ZSa, 7, 28a-f, perME, g867, 5/15/07 TT 23d. Date of								
Sox 6876 leath certificate e attending phy for use as the	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 5 Other (Specify)							
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Division of Vital Records, P.C. pital or Attending Physician: The law requires that ours after death. eral Director: After this certificate has been signed filled in by the funeral director, page 2 should be dete	tion:	1 Natural 5 Pending (Month, Day, Year) 1 Yes 2 X No unk							
ivisic or Atte after des Directo	Certification:	3 Suicide 6 X Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State)							
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit		4 Homicide determined (Specify) house 301/ Independence St. Baltimore, MI 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
To the Hospi within 24 hou To the Funer completely fi	Medical	one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	Σ	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. April 30, 2007							
		30. Name and address of person who completed cause of death (Item 23a)							
0 ,	ate	Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 2017 32. registrar's Signature.							
Regist		31. Date filed (Month, Day, Year) 2007							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month April 26, 2007 **Physician** Lucile J. Davids 12:30 PM M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Gaithersburg Montgomery Wilson Health Care Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 😾 F 363-16-6340 91 June 2, 1915 Director Michigan Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County item 27 is marked other than "natural", or itsms 23a or 28e-f show other traumatic sysnt, the Medical Examinar must be notified at 1 ☐ Yes 2 No Directo Gaithersburg Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20877 USA 301 Russell Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status illed within 72 hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: white 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be lifed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic avant. Ite Maddingone. Elementary/Secondary (0-12) College (1-4or 5+) 12 healthcare nurse 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) John Morduff Fern Parks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Marilyn O'Brien/daughter 9304 Edgewood Drive Gaithersburg, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location · City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Licensee Ronald S wa State Anatomy Board 655 W. Baltimore Street man 21201 Baltimore, MD Enter the disease, of complications that caused the death, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between set and Death Immediate Cause (Final days Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence) Physician/Medical Examine the ettending physicien and the for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 ☐Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death in the past 12 months? Month Day Year page 2 should be detached for 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 1 🗌 Yes 3 Probably 4 Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? na Dementer: Azth 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 1 Yes 2 No 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending 1 ☐ Yes 2 ☐ No death. investigation hours after death uneral Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a
To the Funeral I
completely filled the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D04/15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20/ RUSSELL AVENUE / LAITHERS BULKEY AUS 2. Registrar's Signature 31. Date filed (Month, Day, Year) State 2007 Registrar MAY 0 7

07-03021 Ralph Dia

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

aiph Diaz	State of Maryland / Department of Health and Mental Hy 1- For State Certificate of Death	2007 1401
Physician/	Decedent's Name (First, Middle,Last)	Reg. No. 2. Date of Death Month Day Year Onto beath
edical Examine	Ralph Diaz 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	April 20, 2007 0910 hrs
	1000 Fells Street Baltimore	4c. County of Death
Funeral Director	5. Social Security Number ank 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 1 X M 2 F 70 Yrs. Months Days Hours Min.	8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or unk Foreign Country)
and show any nce.	Usual Residence of Decedent 10a. Stateunk 10b. County unk 10c. City, Town or Location	unk 10d, Inside City Limits unk 1 Yes 2 No
with the Maryland ns 23a or 28a-f show be notified at once.	10e. Street and Number unk 10f. Zip Code	unk 10g. Citizen of What Country? unk
or iter	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced If Yes, Give Year 11. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 1 Yes 1 Yes 2 No	
11215-0036 Id be filed within 72 hours after Aental Hygiene "natural", event, the Medical Examiner veet, the Medical Examiner by Be Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) unk College (1-4 or 5+)	ork done1. 16b. Kind of Business/Industry
21215-0036 und be filed within 72 Mental Hygiene. marked other than c event, the Medical		(First, Middle, Maiden Surname) unk
imore, MD 21215-0036 Pages I and 2 should be filed within ment of Health and houlal Hygiethen and: If item 27 is marked other the or other traumatic event, the Medic or other traumatic area or other traumatic and the Medic or other traumatic area.	19a. Informant's Name/Relationship (Type, Print) O.C.M.E. 19b. Mailing Address (Street and Number or R 111 Penn Street Balt 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	imore, MD 21201 Date 20c. Location - City or Town, State
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and N Important: If item 27 is a injury or other traumatic	1 Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 X Other Specify: in state 21. Signature of Fungal Service Licensee.	200. Eccation - City of Town, State
Dep Dem	Ronald S Wave Director State Anatomy Board	655 W. Baltimore Street
Physician /Medical Examiner	23a. Part I. Enter the dispase, of complications that caused the death. Do not enter the mode of dying, such as cardiac or failure. List only one cause on each line. Immediate Cause (Final disease a Drowning complicating Alcohol Intoxication	respiratory arrest, shock, or heart Approximate Interval Between Onset and Ceath
led nisi Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	
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and and	d. UNPENDED AMENDED	
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Vital hysician: this certif I director,	examiner?	g Home 5 Residence 6 Other: Scene
ion of tending Ph. Jeath. tor: After to the funeral	OT Manual Co. T. All.	28d. Describe how injury occurred Subject drowned while intoxicated
Division of spital or Attending I hours after death. neral Director: After y filled in by the funer Certification:		28f. Location (Street and Number or Rural Route Number, City or Town, State) 1000 Fells Street, Baltimore, Md.
To the Hospital within 24 hours To the Funeral completely filled	(Check and one) Certifying Prysician: To the best of my knowledge, death occurred at the time, date and place, and one) Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at and manner stated.	
	29b. Signature and title of certifier 29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) April 20, 2007
	30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State Registra		
DHMH 17 Rev 1/2001 OCMF 2006	ORIGINAL OF THE PROPERTY OF TH	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** caues 30 2007 /Medical Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner is bur ICOMIC بح 8. Date of Birth Oct 23, 1935 Social Security Number Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Davs 1**X** M 2□ F Months Hours Min. France 71 Director 562-92-1702 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or income. 10c. City, Town or Location 10a State 10d. Inside City Limits 10b. County 1 ☐ Yes 2√ No Director MD Worcester Stockton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21864 4908 Little Mill Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 0 house painter home improvements 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alfred Joseph Denier Marie Louise Collin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Jones/friend 4908 Little Mill Road Stockton, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4X Donation 5 ☐ Qther (Specify) 22. Name and Address of Facility State Anatomy Board Baltimore, MD 21201 21. Signum of Euneral Service Licensee Ronald S. Wade, Director 655 W. Baltimore Street Enter the disease, or complications that caused to be read failure. List only one cause on each line complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) etestatio **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of). Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) should be detached 9 ☐ Unkngwn 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 1 Tyes 3 Probably 4 Unknown Completed this certificate has been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy perform To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes No Other: 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 2 Inpatient 5 ☐ Residence 6 ☐ Other (Specify) 27. Manger of Death Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Natural 2 Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: / 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Name and address of persop who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

Costal

32. Registrar's Signature

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Year)

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31. Date filed (Month, Day,

	1	For State Registrar	State o	f Maryland	•	rtment of Ho			iene 007	14615				
Physicia	ı	 Decedent's Name (First, Middle, Willie Davis 	Last)					2. Date of Death	Day Year	3. Time of Death				
/Medica Examine	e .	4a. Facility Name (If not institution, Sinui Hospital	give street and nui			4b. City, Town, or Baltim	1	y	4c. County of Dead	h				
Funeral Director		213-36-5560	6. Sex 1 X IM 2 □ F	7. Age (In yrs. Ia 71	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Sept 27	Year) Co	hplace (State or Foreign untry) unK				
/land	-	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation		-		10d. Inside City Limits				
death with the Maryland me 23e or 28e-1 show first to Folding at	200	MD			Balti	more			1½ Yes 2[
with th	ב	10e. Street and Number 824 ½ W. Lombar	J C4			10f. Zip Code	.01	11	0g. Citizen of What Co	ountry?				
ne 23	2	11. Marital Status	12. Was Deci	edent Ever in U.S	i. 13. V	Vas Decedent of His Yes, specify Cubar		ecify Yes or No-	USA 14. Race - Ame					
IQ Z IZ I D-UUSO I filed within 72 hours after death wi I Hygiene other than "naturel", or iteme 23a vent, the Medical Examinal must	by runeral Director	1 XNever Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Formed 1 Tyes If Yes, Gir Year or D	2 X No		Yes, specify Cubar ☐ Yes 2 ☐ No	n, мехісап, Риепо Specify:	Hican, etc.)	Black, White Specify: b1					
72 hou	Completed	15. Decedent' (Specify only highes	s Education grade completed)		(Give	ent's Usual Occupa kind of work done d OO NOT use retired)	uring most of work		16b. Kind of Business	Industry unk				
filed within Hygiene. other than "	dulo	Elementary/Secondary (0-12) unk	College (I-4or 5+)	me. L	70 1401 036 16.1160)								
I'RE, INTRIVITATION Z I Z I D-UUSO s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 is marked other than "naturel", or iteme 23s or 28s-1 show other treumatic event, the Medical Examination at the inclined at	10 56 0	17. Father's Name (First, Middle, L	ast)			unk	18. Mother's Nam	e (First, Middle, A	Maiden Sumame)	unk				
Marylan d 2 should be th and Mental 7 le merked treumetic ev		19a. Informant's Name/Relationsh	, City or Town, State, .	Zip Code) unk										
ages 1 and 3 and of Health It: If Ilem 27 y or other tr	-	Vernita McCray/ 20a. Method of Disposition 1 □ Burial 2 □ Cremation 4 □ Donation 5 ₩ Other (Sp	3 Removal from	State 20b. Pla	ace of Dispo metery, cren	sition (Name of natory or other place	e)	Date	20c. Location - City or	Town, State				
Dartimor permit. Pages: Department of t importent: if ite eny injury or of once.		21. Signature Funeral Service Ronal S		irector	St	Name and Address ate Anato 1timore,	omy Board	655 W.	Baltimore	Street				
Physician		23a Part Nenter the disease, or combined to that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Betwoen the disease or condition resulting in death) a. Renal Cell Carcinoma Due to (or as a consequence of):												
/Medical Examiner			Due to	(or as a conseque	ence of):									
per list	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b Due to	(or as a conseque	ence of).									
te be ysicia	iicai Exar	that initiated events resulting in death) Last	c. Due to	(or as a conseque	ence of):									
BOX of sath certific attending process as	nysician/med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live t	tcome of pregnan birth 2 Tetal of hant at time of decown	death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	ivery Day Year				
S, T	2	Part II. Other significant condition	ns contributing to d	eath but not resul	lting in the ur	nderlying cause give	on in Part I.	23e. Did tob	pacco use contribute to	o the cause of death?				
The lay ate has page 2	Completed				· · · · · · · · · · · · · · · · · · ·			24a. Was a autops perform	n 24b. Were a prior to death?	utopsy findings available completion of cause of 2 2 No				
VICO ician sertifi ector	g Q	25. Was case referred to medical examiner?	Hospital:			Othe	261	h (Check only on						
h ya sh	ion: 10	1 Yes 2 No 27. Manner ol Death 1 Natural 5 Pending 20 Accident investig	28a. Date		P/Outpatien 28b. Time of Injury	28c. Injury Work	4 (Nulsing 110		ow injury occurred	icify)				
i or Attending after death. Director: After din by the fune	ertification:	2 Accident investig 3 Surcide 6 Could n 4 Homicide determine	ot be 28e. Place	ol Injury - At hor ing, etc. (Specify)				28l. Location (St City or Town	treet and Number or R n, State)	ural Route Number,				
Hospite 4 hours Funerel	edical	29a. Certifier 1 Gertifyin (Check only one) Medical I	Examiner: On the b	asis of examinati	ion and/or in	estigation, in my op	pinion, death occur	red at the time, d	are and place, and du	s stated e to the cause(s)				
To the within 2 To the complet	Z S	29b. Signature and title of certifier	NA V	9)		29c. License PES- Print) TOSPITAL	number	2	9d. Date signed (Mon					
			who completed cau	se of death (Item	23a) (Type,	Print)		1.00.00	April 26,	2007				
- A		Eileen Zingr. 31. Date liled (Month, Day, Year)	nan, D	O. Sil	nai H	ospital i	of Balt	imore		(3)				
Stat Registra		MAY 0 7 2	007	Park A Standar	ADORA	E.S.								

07-03344 Fatima Ferguson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1- For State Certifica	ate of Death	Reg. No.								
	Physicia	an/	Decedent's Name (First, Middle,Last)		Date of Death Month Day Year	3. Time of Death							
ريد طال	al Exami	ner	FATIMA FERGUSON	4b. City, Town, or Location of Death	May 2, 2007	0833 hrs							
			Facility Name (if not institution, give street and number) Sinai Hospital	Baltimore	4c. County of [Jean							
	Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birt)	hday) If Under 1 Year If Under 24Hrs	8. Date of Birth (MM/DD/YYYY)	Birthplace (State or							
	Director		212-84-9881 1 M 2XF 33 Yrs. Months Days Hours Min. MAR. 4,1974 Fore										
	_	}	Usual Residence of Decedent	113.	7 11,105 1 / 1 / 1	Country) MD							
3	any		10a. State 10b. County 10c. City, Town	or Location		10d. Inside City Limits							
8	Maryland 28a-f show any 1 at ouce.	5	MD NA BAI	LTIMORE		1 Yes 2 No							
	Maryl. 28a-f d at o	ğ	10e. Street and Number	10f. Zip Code	10g. Citizen of What	·							
	ith the Maryland 23a or 28a-f sho notified at once.	₫	3707 Wood BINE AVE.	21207	U.S.A								
	th wit	Funeral Director	11. Marital Status 1 X Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 	pecify Yes or No- Rican, etc.) 14. Race - A White, 6	American Indian, Black, etc.							
	er dea		3 Widowed 4 Divorced If Yes, Give Year	1 Yes 2 No specify:	Specific T	SIACK							
	urs aft tural' amine	ğ	15. Decedent's Education (Specify only highest grade completed) 16a.	Decedent's Usual Occupation (Give kind of v	work done 16b. Kind of Busin								
	72 ho	ete	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use reti									
036	vithin ene. er tha Medic	Completed	il	STOCK Clerk	RETA	1 L							
5-0	uld be filed within 72 hours a Mental Hygiene. marked other than "natural c event, the Medical Examin	ပ္စို	17. Father's Name (First, Middle, Last)		e (First, Middle, Maiden Surname)								
12,	ld be Mental narke event	o Be	WILLIE FERGUSON 19a. Informant's Name/Relationship (Type, Print) 19	b. Mailing Address (Street and Number or F	FERGUSON	State Zin Code)							
MD 21215-0036	oho nd is	-	Susie Ferguson-Mother 3	B707 Wood BINE A	WE BALLO MD.	21207							
<u>ح</u> نه	Pages I and 2 shounent of Health and I ant: If item 27 is I or other traumatic		20a. Method of Disposition 20b. Place	of Disposition (Name of cemetery, tory or other place)	Date 20c. Location - C	ity or Town, State							
nor	ages ent of nt: If	- 1	Burial 2 Cremation 3 Removal from State cremat 4 Donation 5 Other Specify:	Zion Cemeter 5-	8-06 BALT	o. Md.							
Baltimore,	permit. Pag Department Important: injury or of	l Ì	21 Signature of Funeral Service Licensee	22. Name and Address of Facility	C. u. C. c. PA								
ä	E De E	0.1	Michael Ziglier	Zion (eMETER) 5- 22. Name and Address of Facility Nichael Ziglier 3512 Frederich	E Ave, BAIto.	Md.21229							
	nysician Medical		23a. Part I. Enter the disease, conforcations that caused the death. Do not failure. List only one cause on each line.	ot enter the mode of dying, such as cardiac of	or respiratory arrest, shock, or heart	Approximate Interval Between Onset and							
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			bac to (or at a correctation or).										
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760,	cate be ex physician he burial	Mec	IF FEMALE: 23c. If yes, outcome of pregnancy	re, good, 0/15/0/ 11	23d. Date of de	elivery							
<u> 89</u>	leath certific e attending for use as t	sician	Page 12 months.	Fetal death 3 Ectopic pregna	ancy M onth	Day Year							
Box 68	death e atte	ysic	1 Yes 2 No 9 V Unknown 9 Unknown	Other (Specify)									
	at the d d by the tached	/ Phy	Part II. Other significant conditions contributing to death but not resulting	g in the underlying cause given in Part I.	23e. Did tobacco use contribu	ite to the cause of death?							
Division of Vital Records, P.O	ires th signed I be de	d by			1 Yes 2 No 3	Probably 4 V Unknown							
rds	w requir s been s should t	Completed	,			ere autopsy findings available or to completion of cause of							
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<u>~</u>	cian: The certificate ector, page	Be	25. Was case referred to medical	26.Place of Death (Check									
Vit.	hysici this c Il direc	To B	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/O		•	Other:							
οί	tending Ph eath. tor: After t the funeral		1 Motural (Month, Day, Year)	Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred								
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ij	ospital or Attene hours after death meral Director: y filled in by the	Certification:	Suicide La Could not be determined (Specific) Other	arm, street, factory, office building, etc.	28f. Location (Street and Number or Town, State) 4006 Groveland Ave.	Pol+imore MD							
_	lospita † hour unera dy fill		29a. Certifier 4 Certifying Physician. To the heat of my knowledge do										
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	one) 2 Medical Examiner:On the basis of examination and/or										
	5 ± ± 5 0	Me	and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed	(Month, Day, Year)							
	/		(alagetell)	O.C.M.E.	May 3, 2007								
4	1		30. Name and address of person who completed cause of death (Item 23a)										
)			11 Penn Street, Baltimore, MD 21	201								
	S Reais	tate	31. Date filed (Month, Day, Year) NAY 0 7 2007 32. Re Strar's Signature	houself!									

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #1, perMD, 6867, 5/10/07 IT
State of Maryland / Department of Health and Mental Hygiene
24a, 26 per verb. 2867, 05/07/0/dhb

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Reg. No.

Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day JU **Physician** :00 P. M James E. Friday, Sr. Friday gril 2007 /Medical Ficility Name (If not institution, give street and number, 4c. County of Death 4b. City. Town, or Location of Death Examiner Dun senera If Under 1 Year mbia If Under 24 Hrs. HOV card 5. Social Security Number 6. Sex Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 249-48-6056 102M 20 F Months Days Hours Min Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show treumatic event, the Medical Examiner must be notified at 1 Yes 2 No **Funeral Director** toward 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Brook USA or items 23a 21046 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Black þ Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced "nature!" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DONO use repred) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Indus if Health and Mental Hygiene. Item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဝ John Informant's Name/Relationship (Type, Pfi t) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD21046 trida olumbia 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Department of H Important: If its any injury or of once. 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) yland 21. Signature of Funeral Gervice Licensee ral Services 23a. Pan1. Enter the lisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 3 years Coronary artery Immediate Cause (Final disease or condition resulting in death) **Physician** disease /Medical Due to (or as a consequence of): Examiner 10 years Hyperlipidenma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Dav 4 Pregnant at time of death 5 Other (specify) been signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Prostate cancer Cardiomiopathy, propertersian 1 Yes 2 No 3 Probably 4 Unknown peeu 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No page 2 s certificate 2 No director. Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Other: Medical Certification: To 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient TOOA 4 Nursing Home 5 Residence 6 Recity) October this After the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation within 24 hours after death. To the Funerel Director: At 1 Yes 2 No nerel Director: A 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Light Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely 29b. Signature and tive of certifier 29c. License number 29d. Date signed (Month, Day, Year) allhone up DZ1461 may 1,2007 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Yarry Moore 4801 Dorsey Hall Drue Ellworth City 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 7 2007 MAY 0 Transe ! Registrar

			For Amend #5, perFH,	State of Maryland	/ Departmen	nt of Health and N	n copies A lental Hygi	ene 0 0 7	14618		
		1			Certifica	te of Death	2. Date of Death	g. No.	3. Time of Death		
	Physicia /Medic	ın	1. Decedent's Name (First, Middle, Last) MARGUERIT	E ELLEN		BART	Month MAY,	Day Year 2 200 7	7.30 P M		
7	Examin		4a. Facility Name (If not institution, give	street and number)	4b. City	, Town, or Location of Death		4c. County of Deal			
			St. Martin's Home			tonsville er 1 Year If Under 24 Hrs.	8. Date of Birth	Baltimor	thplace (State or Foreign puntry)		
	Funeral Director		216-42-3124	M 2□XF 94		rs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Year) 10/25/1912 9. Bir					
	and	-	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Location				10d. Inside City Limits		
	f sho	ō	MD Balt:	more (Catonsville				1 ☐ Yes X☐ No		
	28a-	Director	10e. Street and Number			ip Code	10	0g. Citizen of What Co	ountry?		
	13a ol	a D	601 Maiden Choice	Lane L605		21228			United States		
ယ	be filed within 72 hours after death with the Maryland the lygiena. All the Wedteal Exam is removed to the Nordical Exam is removed to notified at event, the Medical Exam is removed to notified at	Fur	11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	13. Was Dec	edent of Hispanic Origin? (Specify Cuban, Mexican, Puerto 2X No Specify:	14. Race - Ame Black, Whit				
<u> </u>	ral', c	l by	3 X Widowed 4 ☐ Divorced	Year or Dates:			1				
5	72 h	etec	15. Decedent's Edu (Specify only highest grad	cation e com <i>pleted)</i>	16a. Decedent's Us (Give kind of w life. DO NOT	ork done during most of won		16b. Kind of Business	/industry		
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an	ould be Mental arkad o atic eva	To Be	Maurice Joseph Ne								
Maryland	3395	F	19a. Informant's Name/Relationship (T)		19b. Mailing Addre	ss (Street and Number or Ru	ral Route Number	City or Town, State,	Zip Code)		
	d 2 th a 7 is		James W. Gilbart	(Son)	234 Rolli	ngbrook Way,					
ore,	of Heam	1	20a. Method of Disposition 1 ♣ Burial 2 ☐ Cremation 3 ☐ I		ace of Disposition (Normatory of	ather piace)		20c. Location - City or			
Ĕ	Pages nent of ant: If I		'4 □Donation 5 □Other (Specify,	New	Cathedra	Cemetery 05/	07/2007	Daitinore	e, Maryland		
Baltimore,	permit. Pages 1 and Department of Heal Important: If Itam 2 any injury or othar once.		21. Signature of Funeral Service Licens Mayle T-	neral Home more, Mary	e, Inc. yland 21229						
760,	Physician /Medical Examiner prijar-Itansif	al Examiner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	STAGE 4	Onset and Death TWO YERS SEVERALYER						
.O. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To tha Funaral Diractor: After this certificate has bean signed by the attending physicompietely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnal 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3 Ectopic			23d. Date of de Month	alivery Day Year		
<u>α</u>	res that the de signed by the a be detached to		Part II. Other significant conditions or	ontributing to death but not resu	ulting in the underlying	g cause given in Part I.	23e. Did to	bacco use contribute	to the cause of death?		
ds,	signe signe	d by	TYPE IT DIARETES	MELLITUS	WIF VASO	ULOPATHY,		es 2. 1 <mark>7\$</mark> No 3. □ F	Probably 4 Unknown		
Records,	ne law require I has bean sig ge 2 should b	Completed	ESSENITIAL RETIN	OPATHY, NEW HYPERTEN JERY DISE		AND NEPHROPH NEMIA OF CHR	MESZ beugi	sy prior to			
Vital	ician: The certificate rector, pag	o C	25. Was case referred to medical	CICKI DISC	HISC, INE	VIVG 10 M A	ath (Check only or	7			
>	ysician: The is certificate hadirector, page	o B	examiner? 1 ☐ Yes 2 📉 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA Other: 4 Nursing H	dome 5 ☐ Resid	ence 6 □Other (Sp	ecify)		
of	ding Phy	- :-	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe h	ow injury occurred			
io	Attending Ph er death. actor: After th by the funeral	atio	1 Natural 5 Pending investigation		М	1 ☐ Yes 2 ☐ No					
Division	after de Diracto d in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, street, fact	ory, office	28f. Location (S City or Tow	itreet and Number or F m, State)	Rural Houte Number,		
	To the Hospital or Attent within 24 hours after deatl To the Funaral Director: completely filled in by the	edical C	29a. Certifier 1 X Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my kno- niner: On the basis of examinal and manner stated.	wledge, death occurr tion and/or investigat	ed at the time, date and place ion, in my opinion, death occi	e, and due to the durred at the time, d	cause(s) and manner a date and place, and do	as stated. ue to the cause(s)		
	To thin Within Fo tha Comple	Me	29b. Signature and title of certifier	0.55		29c. License number		29d. Date signed (Moi			
	d.		> Karal	xexay up		D18362	-	5-3-2	4001		
0	2		30. Name and address of person who Komal K. Dang	completed cause of death (Item M-D-, 3455, I	wikeus	Ave, Ste.	-L10.	Balto.	Md21229.		
	St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
The 18 per th 2867 5-7-0/vt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death GOMEZ Day **Physician** ELAINE 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BON SECOURS BATIMORE, MO 2/232 N/A HOSPITAL Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Days 1□ M 2□F Hours Min. 216-20-5707 89 Feb. Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits r 28a-f show notified at N/A Md Baltimore Yes 2□No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ortant: If item 27 is marked other than "natural", or items 23a or In]ury or other traumatic event, the Medical Examiner must be a 1732 Ashburton Street 21216 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2大 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specialack 1 ☐ Yes X☐ No Specify: þ 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If flem 27 is marked other than any Injury or other tranmaria. Elementary/Secondary (0-12) College (1-4or 5+) Own Home 10th grade Housewife 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mable Henson Otho Mackay F ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21133 19a. Informant's Name/Relationship (Type. Print) Thomas B. Wainwright,Jr./Son 4122 Mary Ridge Drive Randallstown,Md 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑Burial 2 ☐Cremation 3 ☐Removal from State Garrison Forest Vet.2607. Owings Mills, Md 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service Licensee 5240 Reisterstown Rd Baltimore, Md 21215 Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ships, or heart failure. List only one cause on each line. Immediate Cause (Final discusse or condition resulting in death) hysician /Medical a consequence of); Examiner -uiSequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as attending properties of the second IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) the 9□Unknown Part II. Other sign, icant conditions contributing death but at resuling in the underlying suse liven in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2☐NO 3☐ Probably 4☐Unknown 1∏Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? uneral director, Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 1 ဥ 1 Impatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natoral 2 Accident (Month, Day Year) 5 Pending 1 ∏Yes 2 ∏No ours after death.

neral Director: A
filled in by the fu death. investigation 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours at To the Funeral D he Hospital Lightifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. anend item 10f per fg 8867 5-7-07 vt.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1:43 A 2007 Hazel Hampton 3 Мау /Medical 4c. County of Death Baltimore 4b. City, Town, or Location of Death Pikesville 4a. Facility Name (If not institution, give street and number) Examiner Milford Manor Nursing Home If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)

S. Carolina 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2√□ F 86 239-36-9856 1920s. Director July 1, Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 ☐ No Pikesville Director Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ms 23a or 7 Pikesville 21208 USA 101 Woodholme Drive Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 7 is marked other than "natural", or Items traumatic event, the Medical Examiner mu 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) New York City Dept. Elementary/Secondary (0-12) College (1-4or 5+) Educator of Education 1 Year 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anna E. Peterson Mordecia Hampton ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2302 Rogate Circle Baltimore, Md 21244 19a. Informant's Name/Relationship (Type. Print)
Tina Hampton/ Niece permit. Pages 1 and 2 Department of Health Important: If item 27 any injury or other tra once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date / 20a. Method of Disposition 5/7/67 Arbutus, Maryland 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Arbutus Memorial Park 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service Licensee Md 21215 5240 Reisterstown Rd Baltimore, 23a. Part! Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) reunine **Physician** /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributin eath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe certificate 25. Was case referred to medical examiner? Be 26. Place Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No neral Director: / filled in by the f 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 2 ☐ Medica within 24 29c. License number 7569 29d. Date signed (Month, Day, Year) 29b. Signature and title of o 18\$ Coreeno Tree Pd 21208

Registrar DHMH 17 Rev 1/2001

State

30. Name and address

31. Date filed (Month, Day, Year)

Registrar's Signature

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 1 200 Landonia Horsey /Medical 4c. County of Death 4b, Gity, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE DITAL If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** Days 216-20-9981 1 □ M 2 1 F 89 Yrs. Director 02/24/1918 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ∏Yes 2 ☐ No Director MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3606 Harlem Avenue 21229 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after un and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: SpecAfrican American þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ianitor Baltimore City PublicSchools unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gertrude Spedden ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any injury or other traun once. Charles Louden / Son-In-Law 3606 Harlem Avenue; Baltimore, Maryland 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crest Lawn Memorial Park 05/07/2007 Ellicott City, Maryland 22. Name and Address of Facility Wylie Funeral Home, P.A. 21. Signature of Funeral Service License 638 North Gilmor Street; Baltimore, Maryland 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Physician 30 minutes INFARCTION /Medical Examiner bATHERUSCLEROTIC CARDINVASCULAR

Due to (or as a consequence of): co years Sequentially net conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner burial-tran Due to (or as a consequence of): ORSCY/ CANDOVIII ivision or Vital Records, P.O. Box 68760, the IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 🕱 No Day 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 Yes HYPERTENSION funeral director, page 2 should Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No SEIZURE DISERDER autopsy perform After this certificate 1□ Yes 2 No or Attending Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2No 1 | Inpatient 2 ER/Outpatient 3DDOA Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred (Month, Day Year) Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director;
completely filled in by the 6 □ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the

State

Registrar

32. Registrar's Signatur TEROME I SNYDOR 31. Date filed (Month, Day, Year)

Lugales in

e and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

CATON AVENUE BALTIMORE MARYLAND 900 SOUTH

29c. License number

2264

MAY 02,2007

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 2007 REVEKA MAY 3 KUPERSTEIN 5:20A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JEWISH CONVALESCENT CENTER BALTIMORE BALTIMORE Age (In yrs. last birthday) If Under 1 Year Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 X F 92 220-21-2058 Director 08/01/1914 ÚKRAINE Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director MD BALTIMORE BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a or 7920 SCOTTS LEVEL Funeral ROAD 21208 USA Items 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race -Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2X No WHITE δ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "ne any injury or other traumatic event, the Medie once. Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be DAVID TEPER 2 ZISLA AZRILANT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) GREGORY KUPERSTEIN / SON 132 TREGARONE ROAD, TIMONIUM, MD 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State ARLINGTON CHIZUKOO AMUNO CONGREGATION 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD 05/4/2007 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee Matt Leunso 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** thin) (o MONA mullab disease or condition resulting in death) /Medical Due to (or as a correquence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9☐Unknown 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 10 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perforc Director: After this certificate in by the funeral director, pag 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 XNo 1 ☐ Yes Other: 1 🗌 Inpatient P 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Division or Vital Records, P.O. Box 68760 within 24 hours a To the Funeral I

> State Registrar

31. Date filed (Month, Day, Year) 0 7 2007

29b. Signature and title of certifie

JADROSONZ 2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

25039

29d. Date signed (Month, Day, Year)

07

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** EVELYN ()5 57. KRASUN 07 01 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner JOHNS HOPKINS BAYVIEW MEDICAL CENTER RALT MOZE r 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🛛 F 217-26-6009 87 Director Jan6,1920 Maryland Usual Residence of Decedent the Maryland 10c, City, Town or Location r 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits Md. Baltimore Dundalk 1 ☐ Yes 2 ☑ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? o e with 716 50th Street ral", or items 23a Examiner must b 21222 USA Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or items 23 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: White 3 □ Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) r than " Elementary/Secondary (0-12) College (1-4or 5+) 8th <u>Waitress</u> Catering 17 Is marked other traumatic event, t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) (unk) Be Frank Wood r 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melvin Krason (husband) 716 50th Street Baltimore, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of I Important: If its any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5-4-2007 Baltimore, Maryland Holy Rosary Cem 22. Name and Address of Facilityaczorowski Funeral Home, PA 21. Signature of Funeral Service Licenses 1201 Dundalk Ave. Baltimore, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CARDIAO MINS resulting in death) /Medical Due to (or as a consequence of): Examiner PESPIRA TURU 12 Hours Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Exami physician and s the burial-trans PNEUMONIA Due to (or as a consequence of): P.O. Box 68760, Physician/Medical SEPS13 ast attending p for use as IF FEMALE 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐Ectopic pregnancy in the past 12 mon 1 Yes 2 No Month Day Year 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy page perform certificate 2 No or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation Injury (Month, Day Year) 1 Natural 2 Accident М 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the t 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

4940 EXISTERUM

32. Registrar's Signature

Page 1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOHNS HOPICUS PRHYVIOW

MAY 0

31. Date filed (Month, Day, Year)

RES-000

MANDIA LANDER, MO

Avenus, BALTIMORES, MD 21224

MAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Date of Death
 Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Physician 12:17A[™] 4, 2007 May Kozarski /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
Oct9,1914 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 🛣 F Maryland 216-58-1562 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene. ant; If item 27 is marked other than "natural", or items 23a or 28a-f show Lry or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 ☑ No Directo Harford <u>Jarretts</u>ville Md. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21084 U.S.A. 1915 Twin Lakes Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: White Specify: Completed by 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) <u>Own Home</u> 8th Home Maker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be fi Department of Health and Mental I-important; If item 27 is marked ot any injury or other traumatic ever Kaczorowski Mary Kaiser John ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 49 Old Sound Road Joppa, Maryland 21085 John V. Kozarski son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State St.Stanislaus Cem 5-7-2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facil Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licensee Pohn 1201 Dundalk Ave. Baltimore, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): iner Exam the attending physician and the defendence as the burial-trans Due to (or as a consequence of): 40 Zarsky Lda M 80036 8 158 Division of Vital Records, P.O. Box 6876 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) detached 9☐Unknown 9 Unknown signed by t Id be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown To the Hospital or Attending Physician: The law requir within 24 hours after death.
To the Funeral Director. After this certificate has been si completely filled in by the funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 | Yes 2 No 2 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27 Manner of Death Certification: 5 ☐ Pending 1 Natural 1 ☐ Yes 2 ☐ No M investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Suicide 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2067 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

2

31. Date filed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

MARPHA

32. Registrar's Signature

Brittney Nichole Larichiuta

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Type of I fill on Die			
State of Maryland /	Department of He	ealth and Mental	Hygiene

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1- For State Certificate of Death Reg. No.										1 11 11 6	
Physicia Medical Examin	n/	1. Decedent's Name (First, Middle,Last) BRITTNEY NICHOLE	CHIU	JTA		Mor	e of Death oth [il 30, 20	Day Year		Time of Death 1217 hrs	
		4a. Facility Name (if not institution, give street and number) 4813 Vicky Road		4t	D. City, Town, or Le	ocation of		,	4c. County of Baltimore		ty
Funeral			In yrs. last birt	hday)	If Under 1 Year	If Under	24Hrs. 8. Da	ate of Birth	(MM/DD/YYYY)		place (State or
Director		218-08-0513 _{1 M 2 X} F	21		Months Days	Hours	Min. M	IAY 9	,1985	Foreign Coun	try) MূD
à à		Usual Residence of Decedent 10a. State 10b. County 10	Oc. City, Town	or Locatio	n		Fa		1-1	1	0d. Inside City Limits
Aaryland 28a-f show any 1 at once.	후.	MD BALTIMORE	NOTTINGHAM					1 Yes			1 Yes 2 XNo
the N a or	Öire	10e. Street and Number 4813 VICKY ROAD	' I			236			U.S.A.		
h with	Funeral	11. Marital Status 12. Was Decedent Education Armed Forces?	ver in U.S.		Decedent of Hisp s, specify Cuban,				14. Race - White,		an Indian, Black,
ifter deat d", or ite	by Fun	I Viveve Marrieu 2 Marrieu	X No			specify:				WHI	
nours a	ᄝ	15. Decedent's Education (Specify only highest grade comp		Decedent' during mo	s Usual Occupation st of working life. I	on (Give ki	ind of work do use retired)	one	16b. Kind of Bus	iness/Ind	dustry
1215-0036 de filed within 72 hou fental Hygiene. aarked other than "nat	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)		DISAB	LED			DI	SAB	LED
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than ic event, the Medica	탉	17. Father's Name (First, Middle, Last)			18	8.Mother's			aiden Surname)		
121! I be fil ental F arked	a	Control of the Contro	ARICHI				VALER		0:1		ANTZ)
	유	19a. Informant's Name/Relationship (Type, Print) VALERIE LARICHIUTA/MOT		_	Address (Street				oer, City of Town		21236
_ = 57 = 2	ŀ	20a. Method of Disposition	20b. Place	of Disposit	tion (Name of cem		Date		20c. Location -		own, State
nor ages 1 ant of 1 other		1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify:	7	ory or oth	er place) REMATOR	Υ	5-4-2	2007	CATON	1SVI	LLE, MD
Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other ti	ŀ	21. Signature of Funeral Service Licensee	11221	22. Na	ame and Address	of Facility	CVACE	I/ROS	SEDALE	FUN	ERAL HOMF
0 5 5 5 5		23a. Part I. Enter the disease, or complications that caused the			11 CHES				EDALE,	MD	21237 Approximate Interval
Physician Medical		failure. List only one cause on each line.				sucii as ca	ildiac or respi	ratory arre	st, shock, or flee	"	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Complications Due to (or as a consequence)		erous	<u>sclerosis</u>						
	Je.	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consecutive form)	juence of):				-				
=	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consection)	uence of):								
760, cate be executed physician and the burial - transit		d.									
ੂ ਛਾੜਾ ਫ	Medical	X UNPENDED AMENDED 27, pe			1/07 TT				23d. Date of	delivery	
8760, tificate be ng physici as the buri		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome 1 Live birth			al death 3	Ectopic	pregnancy		Month	Da	ay Year
Box 68 e death certifi the attending ed for use as t	sician	1 Yes 2 No 9 ✓ Unknown g Unknown	me of death	5 Oth	ner (Specify)				1		
D. B. tr the de by the ached f	Phy	Part II. Other significant conditions contributing to death	but not resultir	ng in the u	nderlying cause gi	iven in Pa	rt 1. 2	23e. Did tol	bacco use contri	bute to ti	he cause of death?
cords, P.O. av requires that the nas been signed by 2 should be detach	<u>5</u>							1 Yes	2 No 3	Proba	ably 4 Unknown
rds, requir	Completed							24a. Was a autops	sy p	prior to co	opsy findings available ompletion of cause of
le CC The lana	dmo						1	ves 2 ✓		death? ✔ Yes	2 No
tal Rection: The certificale ector, pape	BeC	25. Was case referred to medical examiner?				of Death ((Check only o			4 6	
F Vit	2	examiner? 1 V Yes 2 No 27. Manner of Death 28a. Date of Injur		Outpatient Time of Ir	3	y at Work	Nursing Hon		Residence 6 N		Scene
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Division of Vital Records, P.O. Box 68. To the Hospital or Attending Physician: The law requires that the death certificate has been signed by the attending To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, paue 2 should be detached for use as	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Inju	ury - At home, f	farm, stree	et, factory, office b	uilding, et		ocation (Sor Town, St		er or Rur	al Route Number, City
Hospital Hospital Hours Funeral	al Cer	4 Homicide determined (Specify) 29a. Certifier Certifying Physician: To the best of my	knowledge, de	eath occur	red at the time, da	ite and pla	ace, and due t	o the cause	e(s) and manner	as state	d.
To the He within 24 To the Fu	ledical	one) 2 Medical Examiner: On the basis of exam and manner stated.	ination and/or	investigat	ion, in my opinion,	, death oc	curred at the t	time, date a	and place, and d	lue to the	e cause(s)
F * F 8	Me	29b. Signature and title of certifier			29c. License O.C.N				29d. Date sign May 1, 200		th, Day, Year)
		30. Name and address of person who completed cause of de	eath (Item 23a)								-
Ď,		Ling Li, MD Assistant Medical Examiner	111 Per		et, Baltimore, I	MD 212	.01				-
St Regist	ate	14 BV 0 7 2007 Miles	s Signature	-	w						
DHMH 17 Rev 1/2			OI	RIGINA	 L						

amend items 18 Mal 9 an 1940 of the art of t 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Month ONRAD LECATO 324 2 2007 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death UNIVERSITY OF MARYLAND MEDICAL CENTER BAITIMORE N/AIf Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** XXM 2□F 43 204-54-1899 Director Nov.16, 1963 Pennsylvania Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location Item 27 is marked other then "natural", or Items 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at 10d, Inside City Limits Dauphin Harrisburg V☐Yes 2☐No Pa Direct 10g. Citizen of What Country? 10e. Street and Number 2139 Penn Street permit. Peges 1 end 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "natural", or Items 23a eny Injury or other traumatic event, the Mudical Examinar must once. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☑ Married ty∏Yes 2 □ No If Yes, Give Spec frican Baltimore, Maryland 21215-0036 1 ☐ Yes X ☐ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: American Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Year Unemployed 17. Father's Name (First, Middle, Last)
Conrad LeCato, 18. Mother's Name (First, Middle, Maiden Sumame)

Evelyn Cheadle Debo Be Deborah Smith 19a. Informati Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Smith LeCato 2139 Penn Street Harrisburg, Pa 17110 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 € Cremation 3 ☐ Removal from State 5 - 4 - 07Grantville, Pa 4 Donation 5 Other (Specify) Buse Crematory 22. Name and Address of FacilityChatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, Md 21215 21. Signature of Funeral Service Licensee aus 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death SEPSIS **Physician** DEVENE /Medical Due to (or as a consequence of) Examiner PROBABLE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physicien end for use as the burial-transit the Hospital or Attending Physicien: The law requires that the death certificate be executed NECROTIZING Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) deteched 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 Cinknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? this certificate 1 Yes 2□ No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation М Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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DHMH 17 Rev 1/2001

Registrar

MAY 0 7

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2007 April 28, **Physician** 10:10 PM Jerry D. Logan /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore Towson East Motel Towson ## Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. July 9, 1946 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 MM 2 □ F unk 60 Director 212-46-1415 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits ir than "natural", or iteme 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2♥ No Directo MDBaltimore Towson 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1507 E. Joppa Road 21286 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) unk Race - American Indian, Black, White, etc. 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after o Department of Heelth and Mental Hygiene. Important: if them 27 is marked other than "natural; or iten eny injury or other treumatic event, the Medical Exemptons. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: black Š 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Efementary/Secondary (0-12) College (1-4or 5+) unk unk cab driver transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) unk Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) O.C.M.E. 111 Penn Street Baltimore, MD 21201 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 🕅 Other (Specify) in state, 21. Signatury of Euneral Serve Siconsee Wade, Director State Address of Facility Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, ochean failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Landio vascular Physician Artenioselero /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed ig physicien and as the burial-transit Exami Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 夕 icete has been sig 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ♣ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No Be 25. Was case referred to medical 26. Place of Death | Check only one examiner' Other: 4 Nursing Home SX Residence 6 Other (Specify) Hospitaf: 1 Inpatient 2 ER/Outpatient 3 DOA in Hosping.
in 24 hours after death.
the Funeral Diractor: After this c 1 Yes 2 □ No 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Certification: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 To the ŧ 29b Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 01866 completed cause of death (Item 23a) (Type, Print) 6 Hill CT. Lutherville MI Irimble

DHMH 17 Rev 1/2001

Registrar

2. Registrar's Signature

0

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2007 Year 11:37am Elroy C. Langford Jr. 3 May 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Towson Baltimore 8. Date of Birth (Month, Day, Year) Dec. 8, 1931 5. Social Security Number 6. Sev If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1X M 2 □ F 219-30-6616 MAryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Baltimore 1 ☐ Yes 2 ☑ No Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 767 Seawall Road 21221 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Bace - American Indian Black, White, etc. 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes 2 ☐ XNo Specify Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Driver Taxi - Owner 11th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elroy C. Langford Sr. Agnes M. Polacek 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lenora Langford /wife 767 Seawall Road Baltimore MD 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Cemetery 5/7/07 4 □ Donation 5 □ Other (Specify) Baltimore MD 22. Name and Address of Facility 300 Mace Ave. Baltimore MD 21. Signature of Funeral Service Licenses Connelly Funeral Home of Essex 23a. Part1. Enter the disease, or complications that city ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Stroke Acute week disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of trijury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an autopsy 2 No 1∐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 ☐ Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 Pending

Physician /Medical **Examiner** Vital

death certificate be executed ician and burial-tran as use jo ed by the a detached f page 2 certificate Physician: funeral director, After this or Attending within 24 hours after death.

To the Funeral Director: filled in by the Hospital completely

Physician

/Medical

Examiner

MD

Funeral

Director

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ral", or items 23a or 28a-f shov Examiner must be notified at

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permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tr

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Baltimore,

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Medical Certification:

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number

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State Registra

31. Date filed (Month, Day, Xear)

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print).

W. A. R. Ley G. B. M. G. 70 / N. G.

32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar EFF

Year)

31. Date filed (Month, Day,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. edent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year 5:00 AM DNO ONNE 100 07 /Medical alhoun 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 2406 Collège If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) March 27 **Funeral** Birthplace (State or Foreign Country) Months 1 M 2 □ F 9 ') 577-16-245 Usual Residence of Decedent 7-16-295 Director 27,1910 anado filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show event, the Medical Examiner must be notified at **Funeral Director** 1 Yes 2 No 49 altimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2406 21206 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Yes 2 Tiff Yes, Give Year or Dates: 2 □ No Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify. Specify: ģ 3 Widowed 4 ☐ Divorced plack Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life_DQ NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than " any injury or other traumatic event, the Me any injury or other traumatic event, the Me onee. Elementary/Secondary (0-12) College (1-4or 5+) rofessor State Torgan 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be BENJAMIN Thomas ONNE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) endell aNZ 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) - 0 1 butus 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Funeral Home - Harris Varris 4210 21206 Belair 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) 2 🗆 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 Tes 3 ☐ Probably 4 ☐ Unknown Be Completed ERLIPIDEMIA 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy performe certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital: Other: 1 🗌 Yes Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 □Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No after death | Director: / d in by the f 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours af

To the Funeral D

completely filled in 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PHAE LOCH RAVEN ACTIMORE 5607 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar MAY 0 7

DHMH 17 Rev 1/2001

07-02785 Darrel W McNeel

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Darrei VV McNee	•	I- For State	State	ot Maryland /	•	rtment d tificate d			ntai Hy		g. N o.	200	enterior de	
Physicia	n/	Registrar 1. Decedent's Nam	e (First, Middle,Last)						1	2. Date of Death	h	Year	3. Time of Death	
Medical Examin			W. McNee				4h City 1	Town, or Location	n of Death	Month April 12, 20		unty of Death	1611 hrs	
()		521 Carrolto	on Drive	out out and manuacity			Frede		., 0, 5000		Fred	erick		
Funeral Director		5. Social Security N	1	7. Ag		ast birthday) 56 Y	Months Days Hours Min. Foreign							
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tems 23s	Funeral	11. Marital Status Never Marri	unk ed 2 Married	12. Was Decedent Armed Forces?)			as Decedent of Hispanic Origin? (Specify Yes or No- Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Blac White, etc.						
after des al", or i	by Fu	3 Widowed	4 Divorced	1 Yes 2 If Yes, Give Year or Dates:	No	1		X No speci			Spe		ite	
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other transmatic event, the Mackeal Examiner must be notified at once.	leted	Elementary/Sec	ducation (Specify on ondary (0-12)	y highest grade con College (1-4 or				Occupation (Giving life. DO NO			16b. Kind	of Business/li	ndustry unk	
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Baltin permit. Pa Departmer Importan		21. Signature of Fu	X Other Specify: uneral Service Licens Onald &	in state Wade Dir		22 S	Name and	Address of Fac Anatomy	 ^{ility} Board	655 W.	l Balt	imore	Street	
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Division of Vital Records, P.O. Box 68760, within 24 hours after death certificate be executed within 24 hours after death. The reference has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	sician/	IF FEMALE: 23b. Was deceden past 12 month		23c. If yes, outco 1 Live birth 4 Pregnant a death 9 Unknown		2 5	Fetal death		opic pregnat	ncy	23d. D Mo	ate of delivery	y Day Year	
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Division of 'To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director. After completely filled in by the funeral	Certification:	3 Suicide 4 Homicide	6 Could not determined	be 28e. Place of I	njury - At h	ome, farm, s	treet, factor	y, office building	ı, etc.	28f. Location (or Town, S		Number or Ru	ral Route Number, City	
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To To con	Mec	29b. Signature and	d title of certifier	and manner stated	•		29	c. License numb	ber		29d. Date	e signed (Mo	nth, Day, Year)	
		Q _L	ust 2			O.C.M.E. April 13, 2						3, 2007		
		30. Name and add	ress of person who MD. Assistar	completed cause of ort Medical Exar			Street,	Baltimore, M	/ID 21201					
St Regis	ate	31. Date filed (Mor	AY 0 7 200	7 Registra	ar's Signa	ure do	sall?							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 15tate of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 11:50 A M Laura Lynn Mangum /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIMOre 8. Date of Birth May 6,1973 Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Hours Maryland 1 □ M 2 🔀 F 212-19-1934 33 Director Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 10b. County 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyghene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lipiny or other traumatic event, the Medical Examiner must be notified at once. Middle River MD Baltimore 1 ☐ Yes 2€ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA Aldeney Avenue 21220 1538 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1X Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Day Care Day Care Provider 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Roland J. Mangum Jr. Lona Mae Polan -Lona Poland Roland Mangum 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1540 Aldeney Ave. Baltimore MD 21220 father Roland J. Mangum 20b. Place of Disposition (Name of cemetery, crematory or other place)
HOLLY HILL Cemetery 5/8/07 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Baltimore MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. MD 21. Signature of Funeral Service Licensee Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each light Immediate Cause (Final disease or condition resulting in death) toni Physician /Medical Due to (or as a consequence of): Ovarian Carcinoma Examiner retastation if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) 4☐Pregnant at time of death 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 ☐ Natural 28c. Injury at Work? Medical Certification: 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

29b. Signature and title of certifier

29c. License number D0061907

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) 1107

30. Name and address of person who completed cause of death (Item 23a) (Type, Print), Chilkwuma Ebo 1124 Mace

hukwuma

1124 Mace Ave, Baltmore

State Registrar 29a, Certifier (Check only one)

31. Date filed (Month, Day, Year)

32. Rigistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - State Amend #1, perMD, C868, 6/16/07 TT

Cartificate of Daniel

Cartificate of Daniel

Cartificate of Daniel 1. Decedent's Name (First, Middle, Last) Cordella E. McLeod 2. Date of Death 3. Time of Death Day Month Year **Physician** 30P M 07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NIA Baltimore HOSP If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 215-84-4272 1 ☐ M 2 🖫 Director MI Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 HYES 2 No MD Director Baltmone 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ō be 1915 1515 054 or items 23a traumatic event, the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No þ 3 ☐ Widowed 4 ☑ Divorced 'natural", American Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 3altimore, Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) Clerk OFFICE is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be and Mental Thomas ME Millan Sallie Mae ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ME Culloh I mother. Sallie mae MEMILIAN 2431 of Health Baltimore MD 2/207 Department of Heal Important: If item 2 any Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltmore Me Bayvier Com 5/2/07 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Seurce, P. A. 21. Signature of Furieral Service License Han 5/26 Belain Road, Balthrone MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit Due to (or as a consequence of): Physician/Medical as IF FEMALE: use a 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month 4□Pregnant at time of death 5 Other (specify) the 9 Unknown ģ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an as autopsy performed page certificate Vital 26. Place examiner' Other: 4 Nursing Home Hospital: 1 Impatient dire 1 Yes 2 10 10 2 2 ER/Outpatient 3□ DOA 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Certification: Hospital or Attending 24 hours after death. 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 24 hours after death e Funeral Director: 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the within 7 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 202

State Registrar SATPAL S. DANG M. D. 31. Date filed (Month, Day, Year) BALTIMORE

1 ST, HELENA AVE 32 Registrar's Signature

101

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician arroll 2:15 PM Midgett 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Mercy Medical Center N/A 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Min. **t** M 2 ☐ F 245-20-0150 2,1929 North Carolina April Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Middle River Directo Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1407 Shore Road United States 21220 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: <u>ک</u> 3₺ Widowed 4 Divorced White Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Steel Industry 10 Years Diesel Mechanic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ransey Midgett Cora Quidley ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21108 Carroll E. Midgett, Jr. (Son) 8214 Hortonia Point Dr. Millersville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 5/8/2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signal up of Funeral Service Lig Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 Approximate Interval Between Onset and Death Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final congernue heart failure years disease or condition resulting in death) Due to (as a consequence of): Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. preumonia, diabetes, hypertension, 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No disease, peripheral vascular autopsy disease 1☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ٩

Examiner The law requires that the death certificate be executed physician and s the burial-transit Division or Vital Records, P.O. Box 68760, ate has b page 2 s Hospital or Attending Physician: Director: After the

Funeral

Director

r 28a-f show notified at

ral", or Items 23a or Examiner must be r

other traumatic event, the Medical

Department of H Important: If Ite any Injury or ot once.

Physician

/Medical

Pages 1 and 2 should be filed within 72 hours after death

al Hygiene.

and Mental Fishers is marked ot

Baltimore, Maryland 21215-0036

within 24 hours af To the Funeral Di completely filled in To the

27. Manner of Death Certification:

Medical

1 atural 5 ☐ Pending investigation 2 Accident 6 ☐ Could not be 3 Suicide determined 4 Homicide 29a. Certifier

28a. Date of Injury (Month, Day Year) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation in my obliging death. wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifie

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301 St. Paul Place mita Isen, M.D

Baltmore, Maryland 21202

31. Date filed (Month, Day, Year) Registrar

32. Registrar's Signature

07-03277 Barry D. Morris Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

any D. Mome		- For State	or maryland / i		cate of De			, 3	Re	g. No.	U	1453
Physicia	ın/	 Decedent's Name (First, Middle,Las 	st)						Date of Deatl	h		ime of Death
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		4a. Facility Name (if not institution, given University Hospital Shock				altimore	Location o	Deall		40. County of t	Jeaun	
Funeral	7	5. Social Security Number 6. S	ex 7. Age (In yrs. last b	oirthday) If	Under 1 Ye	ar If Under	r 24Hrs. 8	. Date of Birt	h(MM/DD/YYYY)		ce (State or
Director	- 1	213-84-3909 1X M 2 F 45 Yrs. Months Days Hours Min. 11/05/1961 Foreign Court) MD
		Usual Residence of Decedent		- CU T							140-	I. Inside City Limits
w any	1	10a. State 10b. County MD	110	oc. City, Tov	wn or Location	R ₂ 1	ltimore					X Yes 2 No
Maryland 28a-f show any datonce.	횴	10e. Street and Number			10	f. Zip Code	CHIDIC		10	og. Citizen of What		
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72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho		11. Marital Status	12. Was Decedent Ev	ver in U.S.					fy Yes or No-		American	Indian, Black,
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MD d 2 shou lth and n 27 is summatic		Barbara A. Morris /	Wife	1	315 Ly	ndhurst	Street	t; Balı	timore,	Maryland	21229	
ore, M ss 1 and 2 of Health If item 2	-	20a. Method of Disposition 1 XX Burial 2 Cremation 3	Removal from State		e of Disposition natory or other p		emetery,	D	ate	20c. Location - C	ity or Tow	n, State
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Baltimore, permit. Pages 1 at Department of He Important: If ite injury or other tr	ſ	21. Signature of Funeral Service Lice	nsee				ss of Facility			neral Home, imore, Mary		
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/Medical		failure. List only one cause on e Immediate Cause (Final disease	Ach line. Multiple Injuries									Between Onset and Death
Examiner		or condition resulting in death)	Due to (or as a conseq	uence of):								
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Box 687 e death certific the attending	by Physician	past 12 months?	4 Pregnant at tir	me of death		(Specify)		o programo.	,		,	
Bo he deat the at hed for	hys	1 Yes 2 No 9 Unknov	9 UIKIOWII		liine in the unde	- Luina agus	sivon in Da	net I	23a Did to	obacco use contrib	ite to the	cause of death?
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Vita nysicia this ce	To Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 / Inpatient	t 2 EF	₹/Outpatient 3	DOA	Other ₄	Nursing H	lome 5	Residence 6	Other:	
Division of Vital Records, tel or Attending Physician: The law requirer after cent. al Director: After this certificate has been side in by, the funeral director, page 2 should be		27. Manner of Death 1 Natural 5 Deading	28a. Date of Injury (Month, Day Yea Apr 29, 2007	/ 28 ar) 1	3b. Time of Injur 604 hrs	´	jury at Work	· im		how injury occurred collided with a		vehicle
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Hospi 24 hou Funer ttely fil	a	29a. Certifier 1 Certifying Physi	cian: To the best of my	knowledge,	death occurred							
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	Σ	29b. Signature and title of certifier	40				nse number C.M.E.			April 30, 200		Day, Year)
	3	hy h	, m.v	oth /ltor- Co	10)	0.0	J.IVI.⊑.			April 30, 200		
Y		30. Name and address of person who Ling Li, MD Assistant	o completed cause of de Medical Examiner		_{enn} Street, I	Baltimore	, MD 212	201				
S	tate	31. Date filed (Month Day Year)	32. Registrar's			de la						
Regis			L. U V I JUDICOUN									

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ľ	Dhualai	25.	Decedent's Name (First, Middle, Last) A		in A		2. Date of Death Month		3. Time of Death			
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}	Examin	er	4a. Facility Name (If not institution, give street and number) The Johns Mopkins Mos	160	0 11	Location of Death	7-	dc. County of Death				
,	Funeral		5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday	y) If Under 1 Year	If Under 24 Hrs.	B. Date of Birth	9. B	irthplace (State or Foreign			
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	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or I	Location				10d. Inside City Limits			
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	3a or 28 st be no	al Dire	10e. Street and Number 1100 Pennsylvania Avenue		10f. Zip Code	21201	10	og. Citizen of What C USA	Country?			
0030	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy filury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Armed Forces? 1 Yes 2 New Year or Dates:	Ever in U.S. 13	3. Was Decedent of Hi If Yes, specify Cube	ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black, Wi	nerican Indian, lite, etc. an American			
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yıar	should be nd Mental marked c	To E	LLoyd Brown				Rosa Shep					
Mar	nd 2 sh lith and 27 is m r traum		19a. Informant's Name/Relationship (Type. Print) Javetta F. Hammond / Niece		iling Address (Street a							
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	To the Hospital or Attending Physician: The law within 24 buous after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 or	edical (29a. Certifier (Check only one) Certifying Physician: To the best of the deciral Examiner: On the basis of and manner sta	examination and/or	ath occurred at the tir investigation, in my o	ne, date and place, pinion, death occur	and due to the ca red at the time, da	ause(s) and manner ate and place, and d	as stated. ue to the cause(s)			
	To th withir To th comp	Me	29b. Signature and title of certifier		29c. License			d. Date signed (Mo				
)			len Ken	n MD	RES	-000	1	nay 4.	2007			
	4		30. Name and address of person who completed cause of de	ath (Item 23a) (Type	PES e, Print) V. Wolfe	St R.	16 m.	Ma N	21267			
	Sta	te		ar's Signature	1 as.	-11/30	(1,1452)	7,1110	4160+			
	Registr	ar	MAY 0 7 2007	150 B	COMME?							

DHMH 17 Rev 1/2001

7-02991 Roge

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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		or State		Certif	icate of	Deatri		2. Date of	Reg. No.	Year	3. Time of Death
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ic' Examine	_	Roger Po	LLOCK	number)		4b. City, Town, or	Location of Dea	ath	1	:. County of Death Allegany	1
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C.maral	5.	Social Security Numberun		7. Age (In yrs. last	birthday)	If Under 1 Year Months Day		Ain.		Forei	
Funeral Director			1 X M 2 F	53	} Yrs			Feb	11,	1954 L	
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any		a. State 10b. Coun		1	own or Local rostbu						1 Yes 2 X No
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Maryland 28a-f show d at once.	10	e. Street and Number 17706 Mt. Sa	overe Roa	a #3			532			USA	
death with the Maryland or items 23a or 28a-f show must be notified at once.					13 W	as Decedent of H	ispanic Origin?	(Specify Yes	or No-	14. Race - Ame White, etc.	erican Indian, Black,
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Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once injury or other traumatic event, the Medical Examiner must be notified at once	e l		T Divi		19b. Mail	ing Address (St	reet and Numbe	er or Rural Ro	ute Number	, City or Town, St	ate, Zip Code)
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s 1 an of Hea of Hea	- 1	1 Burial 2 Crem	ation 3 Remo	val from State	crematory or						
Baltimore, permit. Pages 1 at Department of He Important: If ite	L	4 Donation 5 V Other	er Specify: in	state	22	2. Name and Add	ess of Facility	and 65	5 W.	Baltimor	e Street
Salti ermit. eparti nport	1	21. Signature of Euneral Se Ronal	d S Wade	Director							Approximate Inter-
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Physician edical		failure. List only one of	ause on each inc.	al gunshot wour							
₄miner		Immediate Cause (Final dis or condition resulting in de-		or as a consequence	of):						
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	ě	Sequentially list conditions if any, leading to immediate cause. Enter Underlying C	e Due to to	or as a consequence	of):						
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SiOr Vitem death sctor:	ite o	2 Accident	Investigation	Apr 18, 2007 28e. Place of Injury - A	At home, farr	n, street, factory,	office building, e				er or Rural Route Number
ivie	Tilled in by the tune	3 Suicide 6	Could not be	(Conside) Multi Es	mily Ant			177			t. 3, Frostburg, MD
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the He	iplete	(Check only one) 2 Med	lical Examiner: On t	o the best of my know he basis of examinati manner stated.	on and/or inv	vestigation,,					ed (Month, Day, Year)
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		Jan	, ~	e on h	LP		O.C.M.E.			, .pii. 10, 2.	
		30. Name and address	of person who comp	leted cause of death	(Item 23a)		D-141	nore MD	21201		
		Tasha Greenbe	erg MD. Assi	stant Medical E	xammer	111 Penn S	treet, Baiun	IIOI e, IVID 4	-1201		
	Sta	Ot Date Slad (Month I		32 Registrar's Si	gnature	Accept 1					
Reg	gistr		Y 0 7 2007	199.00.00	16	A CONTRACT					

			For State Registrar	State of Ma	-	partment of I e <i>rtificate of</i>	Health and M <i>Death</i>	lental Hy	giene Reg. No.	07	14639
			1. Decedent's Name (First, Middle, La	ist)				2. Date of De Month	eath Day	Year	3. Time of Death
	Physici /Medic		Beatrice Ellen	Phelps				Ma		2007	4.55AM
	Examin		4a. Facility Name (If not institution, give			4b. City, Town,	or Location of Death	•	-	ty of Death	
			Genesis Healthc			Baltimor				imore	
	Funeral			Sex 7. Age 1 □ M 2 K F	(In yrs. last birthda	y) If Under 1 Year Months Days		8. Date of Bi (Month, D	ay, Year)	9. Birth	place (State or Foreign ntry)
2	Director		220-46-3459		93 Yrs.			02/14	/1914	Mar	yland
3	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location					10d. Inside City Limits
12	Marylan f show	5	MD Baltimo	re	Baltim	ore					1 ☐ Yes 2 🛣 No
t	the Maryla r 28a-f shor	rect	10e. Street and Number			10f. Zip Code			10g. Citizen o	f What Cou	ntry?
Put	3a or	<u></u>	5505 Gerland Av	onue		21206			U.S.A		
9	me 2	Funeral Director	11. Marital Status	12. Was Decedent B	Ever in U.S. 1		Hispanic Origin? (Spo pan, Mexican, Puerto	ecify Yes or N		ace - Ameri	
K .	or Ite	교	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🛣 N		1 ☐ Yes 2X No		Hican, etc.)		lack, White,	
5-0036	raf', c	by	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		TLI Yes ZALINO	Specity:		Spec	Wr Wr	nite
5-0	within 72 hours after death with the Maryland ene. then "natural", or teme 23a or 28a-f show he Madical Examiner with the notified at	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. De (G	cedent's Usual Occu ve kind of work done	pation a during most of work ad)	ing	16b. Kind of	Business/Ir	ndustry
2	ithin ne ne n	du	Elementary/Secondary (0-12)	College (1-4or 5	+)		ed)				
9 2	led w tygien her ti		17. Father's Name (First, Middle, Last	•1	Hom	e Maker	18. Mother's Name	o /First Middle		Home	
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Z 2	12 should be filed wand Mental Hygies is marked other traumatic event.	ဥ	Unknown 19a. Informant's Name/Relationship	(Time Brief)	10h M	ilian Address /Ptrop	Unknown t and Number or Rura	al Pouto Numb	or City or Tou	m State 7i	n Code)
$\int_{\mathcal{N}} h$	d 2 sl th an 7 is r traur	2 3	Barbara Phelps,			•			-		
	s 1 and 2 should of Health and Mer ilem 27 is marke other traumatic		20a. Method of Disposition	baughter - H	20b. Place of Dis	position (Name of		Date	20c. Locatio		
Baltimore,	ages int of t: If it		1 ☐ Burial 2 🔀 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci			rematory or other pla Svc. Corp		3/2007	Towson	n May	vland
Ē	artme ortan injuri		21. Signature of Funeral Service Lice			22 Name and Addr	ess of Facility			- mai	yranu
ä	permit. Pages 1 Department of H Important: If Ite any Inlury or ott		Alamadais.	Reates		5305 Harf	ord Rd. Ba	onard	J. Ruck	12 12°	•
			23a. Part1. Enter the disease, or con	nplications that caused	the death. Do not						Approximate Interval Between
	Dhysisian		shock, or heart failure. List only Immediate Cause (Final	one cause on each iir	Dhe	umon	16				Onset and Death
	Physician /Medical		disease or condition resulting in death)	a Due to (or as	a consequence of):		101				
	Examiner				4						
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	cuted nd ransi	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c.							
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Вох	death certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 Ectopic pregnanc	су			Date of deliv Month	reny Day Year
o o	the a	Physician/Me	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐Pregnant at 9☐Unknown	time of death	5 Other (specify)					
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ž	ysicien: The I is certificete ha director, page	o B	examiner?	Hospital:	int 2 ER/Outpa	tient 3 DOA	26. Place of Deat			Other (Snec	(fu)
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<u>io</u>	nding F ath. r: After e funer	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		y Year) Injud		Yes 2 □No				
Division of Vital Records,	Atte ar dece ecto by th	1100	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined	28e. Place of Injuding, etc	ury - At home, farm,	street, factory, office	,		(Street and Nu	nber or Rui	ral Route Number,
ā	rs aft ai Dir	Certification:			(-r						
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	(Check only 2 Medical Exa	hysician: To the best of miner: On the basis of	examination and/o						
	the hin 2.	Medi	one)	and manner sta	ated.		nse number		29d. Date sig		
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	~		and a	To Je De Co	1 7 7	2000	73 / 07				200.1
(0		30. Name and address of person who	completed cause of d	Tri (item 23a) (Ty	hads	st. 4	2202	Bust	mos	2 21208
	St.	ate	31. Date filed (Month, Day, Year)		ar's Signature		, ,				
	Regist					D					

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Registrar

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State of Maryland / Department of Health and Mental Hygiene James V. Robinson 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) 3. Time of Death Physician/ Month Day April 20, 2007 Year 2349 hrs **Medical Examiner** James V. Robinson 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 633 N. Aisquith Street #8E **Baltimore** 5. Social Security Numberink If Under 1 Year I If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or unk 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Min. Hours Director Country) Apr 28, 1949 1X M Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 1 X Yes 2 No Baltimore 28a-f shov MD notified at once. the Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21202 633 N. Aisquith Street #8E with ē 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? Never Married 2 unk hours after death Married Yes No black 0 2 No specify: Yes, Give Year Yes Specify Widowed 4 Divorced l other than "natural", the Medical Examiner Ś 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within 72 l Department of Health and Mental Hygiene. Important: If item 27 is marked other than "t injury or other traumatic event, the Medical E Baltimore, MD 21215-0036 unk unk unk 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 111 Penn Street Baltimore, MD O.C.M.E. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Burial 2 Cremation 3 Removal from State Donation 5 A Other Specify: in state 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 21. Signature of Fun, al Service Licensee Ronald S. Wa rector 21201 Baltimore, MD 22 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death Atherosclerotic cardiovascular disease Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical X UNPENDED attending physician for use as the burial #25a,27, perME, G868, 6/7/07 TT Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Month Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. certificate has been signed by þ Yes 2 ✓ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? Yes 2 ✓ Yes 2 No • Hospital or Attending Physician: 3 24 hours after death. • Funeral Director: After this certific etely filled in by the funeral director, p 26.Place of Death (Check only one) 25. Was case referred to medica æ examiner? Hospital: 1 Inpatient 2 DOA Nursing Home 5 Residence 6 V Other: Scene 1 V Yes ۵ 28a. Date of Injury (Month, Day,Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 27. Manner of Death Certification: 1 X Natural Yes 2 No 5 Pending 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State) (Specify) To the Funeral Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier April 21, 2007 O.C.M.E. morrie 30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32 Registrar's Signature 31. Date filed (Month, Day, Year) State

ORIGINAL

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) April **Physician** 30, Franklin R. Souders 2007 9:15 PM /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore
If Under 1 Year | If Under 24 Hrs. 3202 Gorham Court Baltimore Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1√ M 2□ F 233-40-9417 79 Oct. 31, 1927 West Virginia Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Maryland Baltimore Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3202 Gorham Court USA 21227 Funeral within 72 hours after death 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify white 2 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Sheet Metal Mechanic HVAC 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 12 should be finand Mental F. Be William Souders Edith Chapman ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lorina R. Voss / Daughter Health 525 Carlsbad Court, Baltimore, Maryland 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 permit. Pages 1
Department of F
important: If ite
any injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State Crestlawn Mem. Gds. May 4, 07 Marriottsville, Md. 4 ☐ Denation 5 ☐ Other (Specify) 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signature of Funeral Service Licenses 4107 Wilkens Avenue, Baltimore, Maryland 21229 3~ 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on gach line. Approximate Interval Between Onset and Death Immediate Cause (Final M Physician resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No ed by the 9 Unknown should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an 20 No 1□ Yes Hospital or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P in by the funeral 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death After Certification: (Month, Day Year) Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No after death. 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 - Choice love belo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 0 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

ndrew	S.	Smith,	Jr.	

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adic		ysicia xami		1. Decedent's Name (F									Date of Deat Month		Year	3. Time of Death 2030 hrs
euit	Jai E	Xallii	nei	Andrew :			ımber)		4b City To	Month April 10, 200					ounty of Dea	
				334 Barclay Street Salisbury											omico	
		neral		5. Social Security Num	beink	6. Sex	7. Age (In yrs. I	ast birthday)	If Under		If Under	N Aire			Fore	irthplace (State or
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	th with	De De	uneral	11. Marital Status 1 X Never Married	2 Ms	12. Was Dec	cedent Ever in U. orces?		as Decedent Yes, specify				y Yes or No- an, etc.)	14.	Race - Ame White, etc.	erican Indian, Black,
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003	within	Medi	ompleted	17. Father's Name (Fin		0		cook		146	1	Name /Fig	-1 84:33(- 8		starau	int
5.	e filed	it, the	Be C	Andrew		<i>'</i>				10		,	_{st, Middle, M} 1ercer		name)	
213	d bluc	mark ic ever	To E	19a. Informant's Name				19b. Mailin	g Address	(Street a					r Town, Sta	te, Zip Code)
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Ğ	In a start of the Maryland before the Maryland Should be filed within 72 hours after death with the Maryland house of Health and Merial Horizon	Important: If item 27 is marked other than "natural", of injury or other traumatic event, the Medical Examiner.		20a. Method of Dispos 1 Burial 2		3 Removal fr		Place of Dispos crematory or of		of ceme	etery,	Da	ite	20c. Loca	ation - City o	or Town, State
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		ai al niner		Immediate Cause (Fin	al disease	a Diss	eminate		culos	is						Death
				or condition resulting i		Due to (or as a	consequence o	of):								
			Jer	Sequentially list condit if any, leading to imme	ediate	Due to (or as a	consequence o	of):								
			Examiner	(Disease or injury that events resulting in dea	initiated	c. Due to (or as a	consequence o	if):								
	cuted	and transit				d										
_	be exe	the attending physician and ned for use as the burial - transit	Medical	X UNPENDED		AMENDED,	27, perME,	g867, 5/	31/07_T	T				_		<u> </u>
3760	ificate	g phys	_	IF FEMALE: 23b. Was decedent pre	gnant in th	23c. If yes,	outcome of preg	nancy	etal death	3	Ectopic r	oregnancy			ate of delive	ery Day Year
9	th cert	ttendir r use a	Physician/	past 12 months? 1 Yes 2 No	O Limbs	4 Pregr	nant at time of de		ther (Specif	y)						
ď	he dea	y the a	Phys	Part II. Other significa		nown 9 Unkno	own o death but not r	esulting in the	underlying c	ause niv	en in Part	1	23e Did to	bacco use	contribute t	o the cause of death?
О	s that	gned b e detac	þ	Turen. Other signmen	ant conditi	ons contributing to	o death but not t	coditing in the	ariacitying a	aaso gi	on mir un		1 Yes		,	obably 4 Unknown
Ų	require	seen si	eted						•				24a. Was a			autopsy findings available completion of cause of
0	e law	te has l ge 2 sh	24a. Was an autopsy performed? 1 Ves 2 No 1 Ves										·			
<u>~</u>	i ii	ertifica tor, pa	Be Co	25. Was case referred	to medical				26			Check only	Linear		, V	
<u>;;</u>	hysicia	this co	To B	examiner? 1 Yes 2	No		Inpatient 2	ER/Outpatien				Nursing Ho			6 🗸 Oth	er; Scene
o c	ding 7	After		27. Manner of Death 1 XX Natural	Pend	28a. Date (Month	of Injury ı, Day,Year)	28b. Time of	Injury 28	_ :	at Work?		l. Describe h	ow injury	occurred	
.0	Atten Atten	rector:	icati	2 Accident	Inves	tigation 28e Plac	e of Injury - At h	ome, farm, stre	eet, factory, o				Location (S	treet and I	Number or F	Rural Route Number, City
<u>:</u>	ital or	ral Di	Certification:	3 Suicide 6 4 Homicide		not be (Specify)							or Town, St	tate)		
	To the Hospital or when the Physician: The law requires that the death certificate be executed within 34 hours after advantage.	within 24 notes after beaut. To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detach		29a Certifier 1 Ce		ysician: To the bes										
	To the	To the	Medical	1-0		miner: On the basis		and/or investiga				urred at the	time, date a			
			2	29b. Signature and title	d 1 ~	1/4				License O.C.M					1, 2007	lonth, Day, Year)
				30 Name and address	of person	who completed caus	se of death (Item	1 23a)						- F	,	
				Susan Hogan		Assistant Medic			nn Street,	Baltin	nore, M	D 21201				
		e.	ate	31. Date filed (Month, i	Day, Year)	32. Re	egistrar's Signatu	ure								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 6.15 AM Man 200 01 Robert H. Sander /Medical 4c. County of Death 4h. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Hospital Baltimore Good Samanitan If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 ₹ M 2 □ F 94 Aug 9, 1912 New Jersey Director 218-03-6067 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County a or 28a-f show t be notified at 1 □Yes 2√□No Director MD Baltimore Towson 10g. Citizen of What Country? 10e. Street and Number ns 23a must b USA 319 Southwind Road 21204 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items 11. Marital Status Black, White, etc. ا Should be filed within 72 hours after الله and Mental Hygiene. ۱ is marked other than "natural" مع المحد 1 ☐ Never Married 2 ☐ Married white 1 ☐ Yes 2 🗓 No Specify: Specify: þ 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 financial accountant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Health and Mental Elizabeth Dencklau Robert H. Sander 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5800 Waycross Road Baltimore, MD Patricia Whitaker/caregiver 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 N Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License 21. Signature or rune at Service Licensee Rohald S. Wade, Parector State Anatomy Board 655 W. B. Baltimore, MD 21201

23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. State Anatomy Board 655 W. Baltimore Street Approximate Interval Betw Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** mest (an dine /Medical Due to (or as a consequence of); Examiner Cowner Sequentially list conditions, if any, leading to transdict cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Tibri Wation Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No 24a. Was an autopsy performed 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔣 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Maryland 21215-0036

M.D

Saman tan

3. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Good

M.D.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Hospitel, 5601 Lock Reven Blod

RZ-5000

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - Stete Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Dav Year **Physician** Thelma D. Spangler May 2007 11:00P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Manor Care Ruxton
5. Social Security Number 6. Sex If Under 1 Year THUNGER 24 Prs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Months Days Hours 1 □ M 2€ F Director 26.1926Pennsylvania 197-16-3923 Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show other traumatic event, the Medical Examinist must be notified at 1 ☐ Yes 2 XNo Director Towson 10f. Zip Code Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 5 death with or Items 23a 7001 North Charles Street 21204 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 2 **№** No 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: ģ If Yes, Give Year or Dates: i filed within 72 hours a I Hygiene. other than "netural", c 3 ₩Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygiens Important: If Item 27 Is marked other tha any injury or other traumatic event Dry Cleaning Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Paul S. Beecher Carrie M. Null ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen L. Verch/Attorney 12 Darlington Ct. White Marsh Maryland

a. Method of Disposition

Date

20c. Location - City or Town, State

20c. Beginning 2 Cremation 3 Removal from State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) St. Paul 's Cemetery | 5 5/7/07 Hanover, Pennsylvania 21. Signature of Funeral Service Ligensage Marzullo Funeral Chapel, P.A.

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Approximate Course (Table 2) Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Due to (or as a consequence of): attending physician Box 68760 Physician/Medical as the t IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐ Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 2 Hospitel or Attending Physicien: completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 | Inpatient Other: 4 ursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3 DOA 27. Manner of Death 1 X Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Director: After 5 Pending investigation death. 1 Tes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specily) determined after 4 Homicide 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical To the vithin 2 29d. Date signed (Month, Day, Year)

State Registrar DHMH 17 Rev 1/2001 29b. Signature and utto of certifier

31. Date filed (Month, Day, Year)

160

32 Registrar's Signature

SLER Dr. POWSON MD 21204

Leele

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			State of Maryland / Dep	artment of Health and Me		211.17	1.5.6
			1. Decedent's Name (First, Middle, Last)		Reg. I	Noi- O O I	3. Time of Death
	Physicia /Medic		Joseph I.	Vivirito	Month May 3,	Day Year 2007	12:40 A M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
	3		7903 St. Bridget Lane	Dundalk If Under 1 Year If Under 24 Hrs.	0. D. A. (10) (1)	Baltimo	
	Funeral Director		5. Social Security Number 6. Sex 1 ☑ M 2 ☐ F 7. Age (In yrs. last birthday) Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye.	ar) Coun	**
			220-14-7688 80 Usual Residence of Decedent		April 1,		ryland
	irylan show s at	_	10a. State 10b. County 10c. City, Town or Lo			1	0d. Inside City Limits 1 ☐ Yes 24230No
	he Ma Ba-f s	Director	Maryland Baltimore	Dundalk	10=	Citizen of What Coun	
	with t a or 2		10e. Street and Number	10f. Zip Code	Tog.		
	ms 23	Funeral	7903 St. Bridget Lane 11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto R	cify Yes or No-	United St	an Indian,
٥	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give	1 ☐ Yes 2 ☒ No Specify:	nican, etc.)	Black, White, Specify:	White
5-0036	hours ural"; al Exa	d by	3 ∐ Widowed 4 ★I Divorced Year or Dates:		I 16h	. Kind of Business/Inc	
'n	in 72 l i "nat ledica	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation e kind of work done during most of working DO NOT use retired)	¹⁹	. Kind of business/inc	lustry
717	filed within Hygiene. wher than "	шо	Elementary/Secondary (0-12) College (1-4or 5+)	Mechanic		Mainten	ance
and	be filed Ital Hygi d other event, ti	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Maid	den Surname)	
<u>X</u>	2 should be and Menta is marked raumatic ev	2	Frank J. Vivirito		ry Mascar		
Mar	12 sh hand 7 is m traum		, , , , , ,	ing Address <i>(Street and Number or Rural</i> 3 St. Bridget Lane	•		,
	ges 1 and 2 should t of Health and Men if item 27 is marke or other traumatic	1 8	20a Method of Disposition 20b. Place of Disp	osition (Name of Da		. Location - City or To	
altimore,	Pages nent of P int: if ite		1XIBurial 2 □ Cremation 3 □ Hemoval from State	matory or other place) Ht. of Jesus Cem. 5	5/5/2007	Dundalk	Maryland
= = =	+ t t t t t	ľ	21 Signature of Funeral Service Licensee	2. Name and Address of Facility			
ă	permi Depar Impor any ir once.	1	I leady law -	Duda-Ruck Funeral F 1922 Wise Ave. Dun	dalk, Mar	undalk, ir cyland 212	10. 22
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac or	r respiratory arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	A WITH MET	W/asy	1	3 minter
	/Medical Examiner		Due to (or as a consequence of):				
	Mga 1 1276	er	Sequentially list conditions, it any, leading to immediate b. Due to (or as a consequence of):				
	cuted nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.				
Š,	be executed ician and burial-transit	I Ex	resulting in death) Last Due to (or as a consequence of):				
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S S	requires that the death certificate neen signed by the attending phys hould be detached for use as the	Physician/Me	IF FEMALE: 23c. If yes, outcome pf pregnancy			23d. Date of delive	anv.
ROX	death atter	iciar	in the past 12 months? 1 Very 2 No. 1 Very 3 No. 1 Very 3 No. 1 Very 3 No.	□Ectopic pregnancy □ Other (specify)		Month	Day Year
J.	t the c by the	hysi	9 ☐ Unknown				
	w requires that the de been signed by the s should be detached	by P	Part II. Other significant conditions contributing to death but not resulting in the	inderlying cause given in Part I.		co use contribute to the	
Hecords,	requir een si nould	ted			1 ☐ Yes	2 No 3 Prob	2 8
ပ္		Completed			24a. Was an autopsy performed	prior to co	psy findings available mpletion of cause of
Vital	sician; The law certificate has l irector, page 2 s		OF Was seen referred to a Sideal	00 81 (0 11	1 Yes 2		2□ No
	ysician; is certific director,	o Be	25. Was case referred to redical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	26. Place of Death ont 3 DOA Other:		e 6 □Other (Specif	
סר	ttending Physdeath. ctor: After this of the funeral dir	n: To	27. Manual of Death 28a. Date of Injury 28b. Time		28d. Describe how i		<u> </u>
Sio	endin aath. or: Af he fur	atio	2 Accident investigation	M 1 ☐ Yes 2 ☐ No			
Division	if or Attending Physiclan: after death. I Director: After this certifica d in by the funeral director, I	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, si building, etc. (Specify)	reet, factory, office 2	28f. Location (Stree City or Town, S	t and Number or Rura tate)	al Route Number,
	To the Hospital or Atti within 24 hours after de To the Funeral Directi completely filled in by t		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place a	and due to the caus	e(s) and manner as s	tated
	e Hos 24 ho e Fur letely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or i and manner stated.				
	To the within 2 Yo the complet	Me	29b. Signature and title of certifier	29c. License number		Date signed (Month,	
	7		· (44/ 19/)	//49	1193	5/3/0	7
1	U		30 Name and address of person who completed cause of death (Item 23a) (Type	Print - DA - R	1/1 1/	5/3/0	2.2.
	Sta	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	abuel Mr B	JU M	11010	
	Regist		MAY 0 7 2007 Desce & 19	20482			

				n 1 per dr.	, g867, (05/07	707dhib tificate of	Death	vicina i iy	Reg. No:	7 11:	647
	Dhusisi		1. Decedent's Name (First, Middle,	Last) Albert		Wal	leart		2. Date of Dea		3. Tir Year	ne of Death
	Physicia /Medic		brallean	Abe	A-	A1b	ert Walla	ert		24, 2007		7 PM ^M
	Examin	13	4a. Facility Name (If not institution,	give street and numbe	r)		4b. City, Town, or	Location of Death)	4c. County o	f Death	
			Corsica Hills				Centre			Queen		
ľ	Funeral Director		370-54-4044	6. Sex 7. A 1 ☑ M 2 ☐ F	Age (In yrs. Iasi	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da April 2	γ, Υθαr) 9, 1949	9. Birthplace (Si Country)	ate or Equipm
	and wo	ŀ	Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Lo	cation				10d. Insi	de City Limits
	Mary f sho	ξō	MD Kent	t	Cł	ieste	rtown				1 🗆	Yes 21 No
	r 28a	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of Wi	nat Country?	
	h witi	al D	312 Park Row					216	20		USA	
	deat	Funeral	11. Marital Status	12. Was Deceder Armed Forces	nt Ever in U.S.	13.	Vas Decedent of H f Yes, specify Cuba			14. Race	- American India White, etc.	an,
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. d other then "natural", or ftems 23a or 28a-f show event, the Medical Exertified in a vant, the Medical Exertified in a count.	by Fu	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 🏋 Divorced] No			Specify:	ornoun, dio.,	Specify:	white	
5-0	72 hc	Completed by	15. Decedent's (Specify only highest	s Education grade completed)	1	(Give	lent's Usual Occup- kind of work done	luring most of wor	king unk	16b. Kind of Bus	iness/Industry	unk
121	within ene.	mp	Elementary/Secondary (0-12)	College (1-4o	r 5+)	life.	OO NOT use retired)				
	lled lygi thar nt,		unk 17. Father's Name (First, Middle, L	unk ast)			unle	18 Mother's Nam	ne (First Middle	Maiden Surname)	1
an		To Be	, , , , , , , , , , , , , , , , , , , ,	,			unk	io. Monoro o man	to (i ii oi, iiii ooo,	Waldon Garriano	,	unk
Maryland	s 1 and 2 should be f Health and Mental H Itam 27 Is marked of other traumatic eve	F	19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailir	g Address (Street a	and Number or Ru	ral Route Numbe	r, City or Town, S	tate, Zip Code)	-
	Ith (27 I		Corsica Hills N	Nursing Cen	ter	205	Armstron	☑ Avenue	Centre	ville. MI	21617	
ore,	ges 1 ar it of Hea if itam or otha		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □ Removal from Stat	com	e of Dispo	sition (Name of natory or other plac		Date	20c. Location - C		te
Baltimore,	Pa men ant: ury		` 4 □ Donation 5 🂢 Other (Sp	ecify) in stat	e							
Bal	permit. Departi Import any inj		21. Signature of Fundral Service L Ronald S	1/1/1/1/		R-	Name and Address ate Anato 1timore.	MD 2120	11		re Stree	et
	. 1		23a. Part1. Enter the disease, or of shock, or heart failure. List of	complications that cause only one cause on each	ed the death. I line.	Do not ent	er the mode of dyin	g, such as cardiac	or respiratory ar	rest,	Approx Interva	Between
	Physician		Immediate Cause (Final disease or condition	_a_Hen	atic 6	nce	malopa	thin				and Death
	/Medical Examiner		resulting in death)	Due to (or a	s a consequen	ice of):	, ,	,				
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	s donsequen	ce of):					5 4	lays
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events									2.
ó	cate be executed physician and s the burial-transit	Exa	resulting in death) Last	c. Due to (or a	s a consequen	ce of):						
09289	nte be	ledical	(d								
	ing ph	Med	IF FEMALE:	I								
Вох	eath certifi attending i for use as	ian/l	23b. Was decedent pregnant in the past 12 months?		2 🗌 Fetal de	ath 3	Ectopic pregnancy			23d. Date Mont	.,	Year
0.	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the buriat-transit	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnant 9☐ Unknown	at time of death	n 5L	Other (specify)				54,	7 041
Δ.	that the ed by detac		Part II. Other significant condition	ns contributing to death	but not resultin	ng in the ur	iderlying cause give	n in Part I.	23e. Did to	bacco use contrib	oute to the cause	of death?
Vital Records,	uires n sign ild be	Completed by	Coagneopoth	Alcoh	Glie	cica	hosis		1 🗆 Y	es 2 No 3	☐ Probably 4	4 □Unknown
2	w require s been significant	lete	J • •						24a. Was	an 24b. We	ere autopsy findi	ings available
Re	The lay te has age 2	ошб							autop	med? de	or to completion ath? Yes 2 No	of cause of
ita		es e	25. Was case referred to medical					26. Place of Dea	1 ☐ Yes th (Check only o		1105 21010	
of V	> S D	To B	examiner? 1 Tes 2 No	Hospital: 1 ☐ Inpat	tient 2 ER	Outpatien	0the	Nursing H	ome 5 🗆 Resid	ence 6 Other	(Specify)	
D C	fter fter ine		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of In (Month, D	jury 28 Pay Year)	b. Time of Injury	28c. Injury Work	.?	28d. Describe h	ow injury occurred	1	
sio	Attanding or death. actor: After by the fune	catl	2 Accident investigation inves	ation				′es 2□No				
Division	ial or Attand s after death al Diractor: , ad in by the f	Certification:	4 Homicide determin	ned 286. Place of It	njury - At home atc. <i>(Specify)</i>	, farm, str	eet, factory, office		28f. Location (S City or Tow	itreet and Number n, State)	or Rural Route	Number,
	To the Hospital or Attandi within 24 hours after death. To the Funaral Diractor: A completely filled in by the to	edical	29a. Certifier (Check only one) Certifying Condition Certifying Certifying Condition Certifying	Physician: To the bes xaminer: On the basis and manner s	of examination	dge, death and/or inv	occurred at the timestigation, in my op	e, date and place, inion, death occur	and due to the or red at the time, or	ause(s) and manr date and place, an	ner as stated. d due to the cau	se(s)
	To the within To the comp	M	29b. Signature and title of certifier				29c. License	_	_	29d. Date signed (Month, Day, Ye.	ar)
			71 1	-				5173		4/2	1107	
			30. Name and address of person w	tho completed cause of	death (Item 23	a) (Type,	Print	10 1 L	1.11-	Nursin	C+	
	-2			I W DC	IDON I	11. 100	CUIS	ICH FI	1/15	イレントンハ	19 01	<i>(</i> :

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			1- For State Registrar		Cer	tificate of	Death			Reg. No.		
	Physici	an/	1. Decedent's Name (First, Midd	le,Last)					2. Date of D			3. Time of Death
ledica	l Exam	iner		Frederic	k D.	TAT : ~	dhorst_		April 30,	Day Ye	ear	2326 hrs
			4a. Facility Name (if not institution	n, give street and nur	mber)		b. City, Town, or	Location o	f Death	4c. County	of Death	
			Johns Hopkins Bayvie	ew Hospital			Baltimore			1	N/A	
ſ	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Yea	r If Under	24Hrs. 8. Date of	Birth(MM/DD/YYY		
	Director		213-68-8868	1 M 2 F	F 0	Yrs.	Months Days	Hours	Min.	1 10 105	Foreig Co	untry)
			Usual Residence of Decedent	TX IVI Z T	52	115.			Apri.	1 10,195	5]	untry) Maryland
	any		10a. State 10b. County		10c. City,	Town or Location	on			-		10d. Inside City Limits
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J	Maryland 28a-f show 1 at once.	힐	Maryland 10e. Street and Number	Baltimore			10f. Zip Code	ounda:	lk	10g. Citizen of V	Vhat Cou	
	Mar r 28a ed at	Director										•
	death with the Maryland or items 23a or 28a-f sho must be notified at once.		7817 St. Bridg					21222		United		
	h wit	era	11. Marital Status	A	edent Ever in U.: erces?				in? (Specify Yes or Puerto Rican, etc.)		ce - Ameri ite, etc.	ican Indian, Black,
	or it	Funeral	A	1 Yes	2 X No							
,	after	ρ		orced If Yes, Give Year or Dates:			Yes 2 X No			Specify		√hite _
	hours after 'natural'', Examiner		15. Decedent's Education (Spe				's Usual Occupat st of working life		ind of work done use retired)	16b. Kind of E	Business/I	Industry
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93	led within 72 Hygiene. other than '	Ę	12+ Years			Truc	k Driver				cking	J
<u>.</u>	filed with Hygien d other , the Me		17. Father's Name (First, Middle					18. Motner	s Name (First, Middle		*	
21215-0036	2 should be filed within 72 hours after death with the Maryland h and Mental Hygies Mental Hygies 23 or 28a-f sh or 27 is marked other than "natural", or items 23a or 28a-f sh or 27 is marked other than "natural" or items 23a or 28a-f sh or matic event, the Medical Examiner must be notified at once mante event, the Medical Examiner must be notified at once	Be	David Robert 19a. Informant's Name/Relations			10h Mailine	Address (Di-	Nh	ber or Rural Route N	rie Franc		7:- O- d-)
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Σ	nd 2 alth a		Elizabeth Alac	nepand (SI			tion (Name of ce		SW Leesbu	20c. Location	2017	
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Ĕ	Page nent ant: or ot	_	4 Donation 5 Other S		Hi.				5/7/2007			Maryland
Baltimore, MD	permit. Pages I and 2 should be filed v Department of Health and Mental Hygi Important: If item 27 is marked oth injury or other traumatic event, the I		2 nature of Funeral Service	Dicensee	00	22. N	ame and Address	of Facility	cal Home o	of Dunda	1k. 1	[nc
			23a. Part Enter the disease, or		all	7	322 Wise	Ave	Dundalk	. Maryla	and	21222
	ysician		23a. Part / Enter the disease, or allure. List only one cause	complications that ca on each line.	aused the death.	. Do not enter th	e mode of dying,	such as ca	ardiac or respiratory	arrest, shock, or h	neart	Approximate Interval Between Onset and
	Medica! caminer		Immediate Cause (Final disease	IL-novetes	sive ather	cosclerot	ic cardiov	ascula	r disease			Death
` ,			or condition resulting in death)	Due to (or as a	consequence of	f):						
		-	Sequentially list conditions, if any, leading to immediate	b. Due to /or on o	consequence of	f\.						
		ine	cause. Enter Underlying Cause		consequence of	1).						
	.=	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of	f):						
	cuted and trans			d								
	The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit	n/Medical	X UNPENDED	#232.PI	I.27.perM	Œ. g867.	5/23/07 T	T				
8760,	cate b physi he bu	Me	IF FEMALE:	23c. If yes, o	outcome of pregi	nancy				23d. Date		у
.89	he death certificate the attending phy hed for use as the b		23b. Was decedent pregnant in t past 12 months?	I Live b	irth ant at time of de	oth	al death 3	Ectopic	pregnancy	Month		Day Year
Box 68	atten atten or us	Physicia	1 Yes 2 No 9 Un	known g Unkno		5 Oth	ner (Specify)					
B	t the de by the ached t	F	Part II. Other significant condi			esulting in the u	nderiving cause i	niven in Pa	rt I. 23e. Di	d tobacco use cor	ntribute to	the cause of death?
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ord	law rec has bee	를							au	topsy	prior to	completion of cause of
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<u>=</u>	certificate ector, page	e C	25. Was case referred to medica	al			26.Place		(Check only one)			
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of Vital Records,	g Ph fter t neral	-	27. Manner of Death	28a. Date	of Injury	28b. Time of Ir	njury 28c. Inju	ıry at Work	? 28d. Descri	be how injury occu	urred	
	tendin eath. tor: A the fu	ţi		ding	, Day Year)		1	Yes 2	No			
<u>:</u>	er der Frecto	lica		estigation 28e. Plac	e of Injury - At he	l ome, far m , stree	t, factory, office l	ouilding, et	c. 28f. Locatio	n (Street and Nun	nber or Ru	ural Route Number, City
Division	pital or Att ours after d teral Direct filled in by	Certification:		ild not be crmined (Specify)					or Towi	n, State)		
MA		-1	29a. Certifier	hysician: To the bes	t of my knowled	ge, death occur	red at the time. d	ate and pla	ice, and due to the c	ause(s) and mann	ner as stat	ted.
, X	the him be	Medical		aminer:On the basis	of examination a							
	To To]ĕ	29b. Signature and title of certifi	and manner s er	tated.		29c. Licens	se number		29d. Date sig	gned (Mo	onth, Day, Year)
			11/ 1	11/1/1	M/		O.C.	M.E.		May 2, 20	007	
	<		Muna Blu	ssell, VVI	10	220)						
n	1		30. Name and address of person Melissa Brassell, MD	n who completed caus Assistant Me			enn Street, E	Baltimore	e. MD 21201			
V			(14.1)		gistrar's Signatu	4	erin Street, L		-, ב ובט ו			
	-	itate	31. Date filed (Month, Day, Year)	7 2007	gistrar's Signatu	15.	900					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** AJZd Mei /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 8. Date of Birth (Month, Day, Year) 5. Social Security Number age (In vrs. last birthday) **Funeral** 1 M 2□F MD Months Days Min 34 JAN2, 1973 Director Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 28a-f show at a or 28a-f shot be notified a 1XYes 2 No Director BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21201 U.S.A. CHASE "natural", or Items 23a 1606 E. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Maryland 21215-0036 Specify: BIACK þ 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If Item 27 is marked other than any injury or other traumests. Elementary/Secondary (0-12) College (1-4or 5+) Food Service WAITER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WEBB Ross 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) St. BAlto. MD. KIOSS-MOTHER 342 Home STEAD LAVERN Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5-8-07 METTO CrEMATORY BALto, MA. 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Michael Ziglier Fren Svc.P.A.

3512 Frederick Ave. Balto. 21. Signature of Funeral Service Licensee hae BAHO. Md. 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dyling, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician eptil /Medical Due to (or as a consequence of): Examiner Dheirm Jue to (or as a cons quence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed burial-transit Tri red and Due to (or as a consequence of) Box 68760. physician Physician/Medical the as attending for use IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. the detached 9 Unknown 9 Unknown signed by t. d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, à 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed funeral director, page 2 should been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 2 No 1∐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3□ DOA After this Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation Iniury 1 Natural 1 ☐ Yes 2 ☐ No hin 24 hours after death. 2 Accident 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the within 7 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed use of death (Item 23a) (Type, Print)

ાં કારાલ Registrar 2. Registrar's Sign

7 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year Tay MARIE ZELINSKY 2115 PM 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner KESWICK NURSING HOME

5. Social Security Number 6. Sex BALIMORE
If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1□M 21 F Months Days Hours 212-09-3696 Yrs. Director Usual Residence of Decedent e filed within 72 hours after death with the Maryland at Hyglene. Aher then "naturel", or Items 23a or 28a-1 show went, Ite Medical Examinar must be reditled at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21206 U.S.A 6014 WALTHER Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1□ Yes 2 No Specify: WHITE 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) TAILOR CLOIHING permit. Pages 1 end 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JULIUS MAXINUK JENNIE KOSUBUK ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) BALTIMORE, MARYLAND 21214 KENNIA LAZBRONY 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 18/07 HOLY TRINITY CEMETERY ELKRIDSE MARYLAND 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens 2. Name and Address of Facility MARZULLO FUNERAL CHAPEL, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. BALTIMORE MARYLAND 21214 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Brd-sta Physician dementie ears /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed anding physicien and use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy ò Month Day Year 5 Other (specify) page 2 should be detached 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 🗌 Yes 3 Probably 4 Unknown peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy this certificate 1 ☐ Yes 2 🕠 No within 24 hours efter death. To the Funerel Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Medical Certification; To Be 26. Place Jeath Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 1 Inpatient 3□ DOA 2 ER/Outpatient 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D13657 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Megregor 700 6 40 th STREET, BALTIMORES MAIZI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

		For State Registrar	State of M	aryland		artment of F		d Mental Hy	giene ,	2007	14651
Physic /Med		1. Decedent's Name (First, Middle,	H. ,	Andoi	/seK			2. Date of De Month	Day 21	Year	3. Time of Death 2153 M
Exami Funeral Director	ý.	4a. Facility Name (If not institution, COASTAL HOS 5. Social Security Number 116–20–9862	Dice at the	L La ge (In yrs. las	lle st birthday) Yrs.	4b. City, Town, o Sould If Under 1 Year Months Days	Shury If Under 24		th iy, Year)	9. Birth	
TD.		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo			10/3/.	1927	Ivew	10d. Inside City Limits 1 X Yes 2 □ No
h with the M 23a or 28a-f st be notifie	al Director	Maryland Worce 10e. Street and Number 15 Hatteras St		Oce	ean P	10f. Zip Code 21811	•		10g. Citize	en of What Cou	-
paritimities in the light of the light of the land of the many permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at anne.	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Marrie 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? d 1 2 Yes 2 1 If Yes, Give N Year or Dates.)		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 No	lispanic Origin an, Mexican, F Specify:	? (Specify Yes or No Puerto Rican, etc.)		I. Race - Amer Black, White Specify: W	
within 72 house.	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	S Education grade completed) College (1-4or 3	- 74	(Give life. L	dent's Usual Occup kind of work done DO NOT use retired Ctrical B	during most of d)		-	d of Business/li Electri	
VICI YICILIO Z IZ. 12 should be filed withir h and Mental Hygiene. 7 is marked other than traumatic event, the Me	To Be Co	17. Father's Name (First, Middle, L Louis Andolsek	I		DIE		18. Mother's	Name (First, Middle Voncina			
G, Mical) 1 and 2 sho Health and I em 27 is ma ther trauma		19a. Informant's Name/Relationsh Madelyn Andolse 20a. Method of Disposition		20b. Pla	15	ng Address (Street Hatteras sition (Name of	and Number of St., C	or Rural Route Numb Ocean Pine	s, MD	7 21811 21811 ation - City or 1	
pariminore, M permit. Pages 1 and 2 Department of Health Important: If item 27 i any injury or other tra		1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (Sp 21. Signature of Funeral Service L	ecify)	cer	sbury. 22	matory or other place Cremato Name and Addre	ry 4,	/23/07	Sali ofess	.sbury, ional A	MD ssociation
	100	23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final	complications that cause only one cause on each I	d the death.	Î.	501 Snow	Hill R	d., Salis	oury,	MD 218	Approximate Interval Between Onset and Death
Physician /Medical Examiner		disease or condition resulting in death) Sequentially list curditure, if any, leading to immediate cause. Enter Underlying	Due to (or as	HEI	MAY	2's 2	RSPLA	SBASE 45E	•		
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VISIOII OI VITAI INCOLLAS, F.O. BOX 00/00, Attending Physician: The law requires that the death certificate be executed er death. rector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Accident investig: 3 Suicide 6 Could no 4 Homicide determine	ot be 28e. Place of in	ury 2 ay Year)	R/Outpatier 28b. Time o Injury ne, farm, str	f 28c. Inju	er: 4 ☐ Nursi	28f. Location (idence 6 how injury	occurred	ral Route Number,
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical Cer	29a. Certifier 1 2 rtifying (Check only one)	Physician: To the best examiner: On the basis of and manner s	of examination	ledge, deat on and/or in	h occurred at the ti vestigation, in my	me, date and opinion, death	place, and due to the occurred at the time	cause(s) a	and manner as place, and due	stated. to the cause(s)
To the within To the comple	Me	29b. Signature and title of certifier 30. Nam and address of person v	n		OSa) /Tyro	29c. Licens		410		signed (Month	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 28b per me 286/5-7-0/vt.
State of Maryland 7 Department of Health and Mental Hygiene 11652 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 04 Day Year **Physician** Barton 15:15 M Gary 2007 30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ballimore of UniVersiTy Maryland If Under 1 Year If Under 24 Hrs. | | Months | Days | Hours | Min. | 5. Social Security Number 8. Date of Birth (Month, Day, Year) 9/21/1961 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 10XM 2□F Months Yrs. 45 Mary land Director 261-77-9568 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director MD Harford Street 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1146 Priestford Road 21154 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 → No If Yes, Give X 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Specify: Completed by 3 ☐ Widowed 4 🏋 vorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Owner/Operator Commercial Cleaning 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mildred Giles Edward Barton 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 Waugh Avenue, Glyndon, Maryland Renee Guckert/Attorney 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 MCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evans Eagle Crematory 5/3/2007 Leola, PA 21. Signators of Funeral Service Licenses 22. Name and Address of Facility Harkins Funeral Home, Inc., Delta, PA 17314 P nt1 End it the disease, or a polications that caused in death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MulTiple Injuries disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** ICAL EXAMINES Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit TON APPROVED BY resulting in death) Last Due to (or as a consequence of): CERTIFIC Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 1 Yes 2 No 9 Unknown 9 ☐ Unknown signed by 1 Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? β 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown been si should t Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' certificate 1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 / Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 No ၉ 2 ER/Outpatient 3 DOA this After thi 28b. Time of Injury 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 1 Natural 5 Pending MOTORCYCL CYCSH

281. Location (Stre and Number or Rural Route Number,
City or Town, State) Popler Grove Rd +

Prinstford Rd, Orling Ton My 22:00 M investigation 1 ☐ Yes **2** ₹ No 4-23-07 2 Accident 3 ☐ Suicide the f 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

STreeT filled in by 4 | Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 6200 4/30/2007

State Registrar

31. Date filed (Month, Day, Year)

2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

05E10 1 CAH1 22 S G ICENS 32 Registrar's Signature

BARTIMORE

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Apr 26, 2007 6:00 pm ^м Kenneth Bowman /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany 939 Gay Street Cumberland If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov 5, 1933 9. Birthpface (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 ☑ M 2 ☐ F Months Days Hours Min. Yrs. 214-30-9630 73 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "naturel", or Iteme 23a or 28s-f ehow any Injury or other traumatic event, the Medical Examinar must be notified at once. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Allegany MD Cumberland 1 ¥Yes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 939 Gay Street 21502 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: white 2 1958-60 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Efementary/Secondary (0-12) College (1-4or 5+) CSX Railroad machinist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Maggie Bowman Butler unknown ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 939 Gay Street Cumberland MD 2 19a. Informant's Name/Relationship (Type, Print) MD 21502 Shirley Bowman wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State 1 Deuriaf 2 Cremation 3 Removal from State **Davis Memorial Cemetery** 4/29/2007 MD Cumberland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fluneral Service Licensee 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 a. This Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Chronic obstructive fmmediate Cause (Final **Physician** disease or condition resulting in death) year /Medical Due to (or as a consequence of): Examiner Sequentiafly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physicien end hed for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Dav 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown à signed t 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Corona dispuse 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No this certificete has been si-at director, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan 1 Yes 2 No After this certification funeral director, 25. Was case referred to medical Be 26. Pface of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home SEResidence 6 Other (Specify) 2 1 Yes 20 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Naturaf 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation rector: / 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Pface of fnjury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide ā within 24 hours a To the Funeral C 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State

Registrar DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

ESUS 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (ftem 23a) (Type, Print)

m.D.

32. Registrar's Signature

ORIGINAL

BROADWAY ST.,

5/1/2007

FROSTBURG, MD 21532

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2007 BARBARA BAKER Α. April 3:27 p M 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Takoma Park Montgomery Washington Adventist Hospital 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Year) | Nov. 20, 1953 Birthplace (State or Foreign Country)
 DC 5. Social Security Number 1 ☐ M 2 🕱 F 577-76-3504 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Prince Georges New Carrollton 10e. Street and Number 10g. Citizen of What Country? 20784 USA 8308 Donoghue Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2K No Specify: Specify: 3 ☐ Widowed 4 ☑ Divorced Balck 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MCI Communications 12th Accountant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Helen Jones L. P. Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberly Davis-Brown/Daughter 409 36th St NE Washington, DC 20019 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☑Cremation 3 ☐Removal from State Metropolitan Crematory 4/28/2007 Alexandria, VA. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Addess of Facility Marshall's Funeral Home, Inc. 4217 9th St. N.W. Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cancer -una Due to (or as a consequence of) ulmonar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 4 Pregnant at time of death 9 Unknown 9 Hunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 Tes 21 No 25. Was case referred to medical examiner? 26. Place of Death | Check only one 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide 1. Partiting Physician: T. the bast of my knowledge, death oncurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

State Registrar

Physician

/Medical

Examiner

Funeral

Director

ir than "natural", or Itema 23a or 28a-f show the Medical Examiner must be notified at

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any fujury or other traumatic event app.

Physician

Examiner

/Medical

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Certification:

Medical

29b. Signature and title of certifier

with the Maryland

filed within 72 hours after death

Baltimore, Maryland 21215-0036

32. Registrar's Signature

7600 Carroll

(m)) 29d. Date signed (Month, Day, Year)

07

State of Maryland / Department of Health and Mental Hygiene U U / Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April **Physician** $2\mathbf{I}^{\text{Day}}$ 2007 7:30 A M BRUEY, JR. ALPHONSUS J. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 4780 Jacksonville Road Crisfield Somerset If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Sept. 20, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 XM 2 □ F Pennsylvania 165-14-9897 86 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2XNo Director Crisfield Maryland Somerset 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code or Itams 23a 21817 IISA 4780 Jacksonville Road Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If frem 27 is marked other than "natural", or Itan any injury or other traumatic event, the Medical Evantment 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: Š 3 NWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PROCUREMENT MANAGER DEFENSE SUPPLY CENTER 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alphonsus J. Bruey Mary Cassady 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Christensen (Daughter) 4780 Jacksonville Road - Crisfield, Maryland 21817 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Holy Sepulcher April 25, 2007 Philadelphia, PA Signature of Funer Stripe Licensee

Mary Beth Bradshaw-Pruitt 22. Name and Address of Facility Bradshaw & Sons Funeral Home 306 W. Main Street - Crisfield, Maryland 21817 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician SCVD /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): attending physician Box 68760, Physician/Medical the as IF FEMALE esn s 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Live birth 2 Fetal death in the past 12 months? Month Day Year 4 Pregnant at time of death P.O. I 5 Other (specify) the a 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed? Yes 2 No 2 □ No 1 Yes 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes No No 10 this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Certification: 1 Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No within 24 hours after deat To the Funeral Director: 6 Could not be 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D48098 April 21, 2007

State Registrar 31. Date filed (Month, Day, Year)

APR 2 3 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10

Vijay Karumbunathan, M.D. - 201 Hall Highway - Crisfield, Maryland

			1 - For State Registrar	State of	Marylan		artmen rtificate				_	gien Reg. No	6001	14658
	I I.E.		1. Decedent's Name (First, Middle, Las	st)							2. Date of De	ath		3. Time of Death
	Physic /Medi		Francis Joseph	Broglie						A	Month April	18 ^{Da}	2007	11:00PM M
	Examir		4a. Facility Name (If not institution, give	street and num	iber)		4b. City,	Town, or	Location of	of Death		40	c. County of Dea	
1			6645 Pine Top Roa	ıd			Hur1	ock					Dorches	ter
	Funeral		5. Social Security Number 6. S		7. Age (In yrs. i	last birthday)	If Under		If Under		8. Date of Bir	th	9. Bir	thplace (State or Foreign ountry)
	Director		216-16-0788	ĎM 2□F	85	Yrs.	Months	Days	Hours	Min.	Month, Da Dec. 1	1 rear	1921 Mai	ryland
	p .		Usual Residence of Decedent											
	how	_	10a. State 10b. County		10c. City	y, Town or Lo	cation							10d. Inside City Limits
Y	e Ma	cto	Maryland Dorchest	er	Hu	ırlock								1 ☐ Yes 2 X No
7	th th	Oire	10e. Street and Number				10f. Zip	Code				10g. C	itizen of What Co	ountry?
7	death with the Maryland me 23a or 28a-1 ehow rmust be notified at	Completed by Funeral Director	6645 Pine Top Roa	ıd			21	1643					USA	
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9	afte or it	F	1 Never Married 2 Married	1 XYes If Yes, Give	2 □ No 194	7	1 □ Yes 2		Specify:		, 010.7	i		
21215-0036	irali,	d b	3 XWidowed 4 □ Divorced	Year or Da	e 194	10	10103 2	21/11/10	Specify.				Specify:	White
5	72 h	ete	15. Decedent's Ed (Specify only highest gra			16a. Deced	dent's Usua kind of wor	l Occupa	ition <i>turina m</i> osi	t of workin	a	16b. k	Kind of Business	/Industry
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7	ygier f.	S		4		Mecha	inica]	L Eng						facturing
	d off	Be	17. Father's Name (First, Middle, Last)						18. Mothe	er's Name	(First, Middle,	Maidei	n Sumame)	
<u>X</u>	Men Men arke	ဥ	Frederick F. Brog	lie							Lanca			
Maryland	and and seum		19a. Informant's Name/Relationship (7	,, ,		1	ng Address	(Street a	nd Numbe	er or Rural	Route Numbe	er, City	or Town, State, 2	Zip Code)
≥ `	and ealth n 27		Francis J. Brogli	e III/G	randson	6645	Pine	Top	Roa	d, Hu	ırlock,	Ma	ryland 2	21643
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or iteme 23a or 28a-1 show wayl righty or other traumatic event, the Medical Examinational Be notified at once.		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐	Domoval from S		lace of Dispo emetery, cren	sition (Nam	ne of ther place)	Da	ite	20c. L	ocation - City or	Town, State
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	/Medical		disease or condition resulting in death)	a	or as a consequ	BYO V	معص	101	M	ccide	int			8 Months
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_,	al-tra	Examiner	resulting in death) Last	C. Due to (c	or as a consequ	ience of):								
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×	eath certific attending p	N.	IF FEMALE:	23c. If yes, outc	ome of pregnar	ncv							and Data of dal	
Вох	atter for u	ciar	23b. Was decedent pregnant in the past 12 months?		th 2 ☐ Fetal .nt at time of de		Ectopic pre						23d. Date of del Month	Day Year
P.O.	at the de by the tached	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknov		,u 5_	other (spe	,c.,y,						
σ.	that the		Part II. Other significant conditions co	ontributing to dea	ath but not resu	Ilting in the un	nderlying ca	use give	n in Part I.		23e. Did to	obacco	use contribute to	the cause of death?
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ě	has has	du			·						24a. Was autop	sy	prior to d	topsy findings available completion of cause of
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Zit.	Physician: this certific ral director.	Be	25. Was case referred to medical examiner?	t to opinion				1 -		of Death (Check only o	nej		
of	Physic this c	٩	TES DINO			ER/Outpatient			4 🗆 1901	rsing Home	e 5 Resid	dence	6 ☐Other (Spec	cify)
	te a	Certification:	27. Manner of Death 1. Natural 5 □ Pending	28a. Date of (Month	Injury , Day Year)	28b. Time of Injury		3c. Injury Work	at ?	28	ld. Describe h	now inju	iry occurred	
Sic	Attending r death. ector: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be	100			М	1 🗆 Y	es 2 🗆 N	No				
Division	irect	틥	4 Homicide determined	288. Place c	of Injury - At hor g, etc. <i>(Specify</i>)	me, farm, stre	eet, factory,	office		28	If. Location (S City or Tow	Street ar	nd Number or Ru e)	ıral Route Number,
	ral D													
	10sp 4 hou Fune ely fii	ca	29a. Certifier Certifying Phy onel 2 Medical Exam	sician: To the biner, On the bas	est of my know	vledge, death	occurred a	it the time	e, date and	d place, an	d due to the	cause(s	and manner as	stated.
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the to	Medical		and manne	er stated.						- at the tille, (GELO AIT	s piece, alla ade	to the causa(s)
	5 <u>1</u> 5 0	~	29b. Signature and title of certifier	11	1-		- 1	License					ite signed (Monti	
	î		THE NEW YORK THE PARTY OF THE P	/	5		- 1	47	492	1		4	/20/200	7
			30. Name and address of person who c	ompleted cause	of death (Item	23a) (Type, I	Print)			65			2	
			Jeff Denton,	m.p. o	555 C	Knwoo	d Dr	ve	Equ	ston.	Many	land	120/200	
	Sta	te	31. Date filed (Month, Day, Year)	32. Re	gigar's Signa	ure		-		,	,		-	

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760,

			For State	State of Ma	aryland	•		nt of He <i>te of D</i>		Mental Hy	-	Em U U	1	14659
			Registrar 1. Decedent's Name (First, Middle, Later)	st)			tinca	10 01 D	Catri	2. Date of D				3. Time of Death
	Physici									Month	0.1	ay Y	ear	06:00 PM
	/Medic Examin		Burton M. Brace 4a. Fecility Name (If not institution, give				4b. City	, Town, or I	Location of Deat	April	4	c. County of		U0:00 PM
_	Funeral		520 South Main St 5. Social Security Number 6. S		. 114 e (In yrs. Ia 72	st birthday)			IS t If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D Januar	rth	Ce (Birthpla	ace (State or Foreign
	Director		004-32-8420 Usuel Residence of Decedent	-X	14	Yrs.				Januar	у Э,	1935 1	1855	achussetts
	land ow		10a. State 10b. County		10c. City,	Town or Lo	cation						10	d. Inside City Limits
	Mary feb	to	Maryland Cecil		Nor	th Eas	st							1 X Yes 2 □ No
	h the	Director	10e. Street and Number				10f. Z	ip Code			10g. C	itizen of Wha	at Count	ry?
	th wil	a	520 South Main St	reet, Apt	. 114		2	21901			Uni	ted Si	tate	S
	r dea	Funeral	11. Marital Status	12. Was Decedent I	Ever in U.S	. 13.	Was Dec	edent of His	panic Origin? (S , Mexican, Puer	pecify Yes or N o Rican, etc.)	0-	14. Race - Black,	America White, e	
36	72 hours after death with the Maryland naturel; or Iteme 23a or 28e-f ehow dical Examiner must be natified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Tyyes 2 ☐ N If Yes, Give Year or Dates:	lo 1952-l	60	1 🗆 Yes	2 √ No	Specify:			Specify:	Whi	te
215-0036	ture	edt	15. Decedent's Ed				dent's Usi	ual Occupat	tion		16b	Kind of Busin		
15		Completed	(Specify only highest gra Elementary/Secondary (0-12)	de completed)		(Give	kind of w		uring most of wo	rking	, , ,			
212	d within Siene.	mo;	1.2	College (1-4or 5	+)		[each	ner			E	ducati	Lon	
9	al Hyg	Bec	17. Father's Name (First, Middle, Last)						18. Mother's Nar	ne (First, Middle	e, <i>Maid</i> e	n Sumame)		
Maryland	Ment Ment arked	T O	Lee Brackett							<u>a Merri</u>				
Mar	2 sh and lam reum		19a. Informant's Name/Relationship (nd Number or Ru					
e,	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hyglene. Item 27 is marked other than "naturel", or Iteme 23s or 28e-f show other treumatic event, the Medical Examinar must be confilled at		Helga Brackett / 20a. Method of Disposition	wire	20b. Pla	ce of Disno	sition (Na	ame of		, Apt. I		NOTEN Location - Cit		t, Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than eny injury or other freumatic event, the Magnee.		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		cer	metery, crei	natory or	other place	1-1-					
Ħ	artme ortan injur		21. Signature of Funeral Service Lice.		May	erdale		emator and Address		2007 rouch F		ark, I		ware
a	Depared Important		1/1/1/4						O					yland21901
			23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that caused	the death.				111111111111111111111111111111111111111					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Le	iK	en	~i	a						Opset and Death
1	/Medical		resulting in death)	Due to (or as	a conseque	ence of):								
1	Examiner	L	Sequentially list conditions,	b									_	
	bed nsit	ulue	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseque	ence or):								
_=	xecul and al-trar	хап	that initiated events resulting in death) Last	c Due to (or as	a conseque	ence of):				-			-	
68760,	icate be executed physicien and s the burial-transit	edical Examiner	(d.										
-														
Вох	law requires thet the death certifes been signed by the attending 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			DEctopic i	pregnancy				23d. Date o		
	e dea the at ned fo	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at 9☐Unknown			Other (s	specify)				Month		Day Year
P.0	het th d by i	Phy	Part II. Other significant conditions of	ontributing to death b	it not result	ting in the u	nderwing	Called Cive	o in Part I	23e Did	tobacco	use contribu	ite to the	e cause of death?
Records,	signe d be	d by	, an in outer organical contained	ontined and to document		ing in the s	indonying	oudso give						ably 4 Onknown
20	w requir been s	ete	7							24a. Wa	6 20	24h Wa	ro auton	sy findings available
Re	The lay ate hes page 2	Completed								auto peri	opsy ormed?	orio dea	r to com	pletion of cause of
ta	ifficati or. pa	a)	25. Was case referred to medical					_	26. Place of Dec	1 Yes		6 1L	Yes	2 0 40
of Vital	Physicien: The k this certificate he ral director, page 2	To B	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatie	nt 2 E	R/Outpatier	nt 3 🗆 🗆	Other		lome 5 Thes		6 ☐Other	Specify)
0	ng Phys Iter this neral di	inc	27. Manner of Death 1 ☑ Maturat 5 ☐ Pending	28a. Date of Injur (Month, Day	y Year) 2	28b. Time o Injury	f	28c. Injury Work	at ?	28d. Describe	how in	ury occurred		
Sio	Attending r death. ector: After by the fune	catle	2 ☐ Accident investigation				М	1 🗆 Y	es 2 🗆 No					
Division	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Hornicide determined	28e. Place of Inju- building, etc	iry - At hon c. <i>(Specify)</i>	ne, farm, str	eet, facto	ry, office		28f. Location City or To			or Rural	Route Number,
	pitel ours e eref [29a. Certifier 1 Certifying Ph	ysician: To the best of	of my know	lodge deat		d at the time	data and place	and due to the		a) and mana		and a
	To the Hospitel or Attending Phwithin 24 hours effer death. To the Funerel Director: After the completely filled in by the funeral	Medical	(Check only 2 Madical Exar	niner: On the basis of and manner sta	examination	on and/or in	vestigatio	n, in my opi	inion, death occi	irred at the time	, date a	nd place, and	due to	the cause(s)
	To th within To th comp	₩	29b. Signature and title of certifier)			25	9c. License	number		29d. D	ate signed (/	Month,	bay, Year)
			()L			0	W	DO	0564	49	4	112	3/	07
			30 Name and address of person who	completed cause of d	eath (Item :	23a) (Type.	Print) / /	10	10	1 70	2	011	1/	10 210-1
4	4+1VA		31. Date filed (Month, Day, Year)	32. Rehistra	111	wes	11	igh D	t- Du	ite SU	1	-11/0	nu	WX1921
,	Sta Registr		APR 2 3	2007 32. De gistra	as a signation	B. 1	parte							/

			1 - For State Registrar	State of Maryland	/ Depa	artment of tificate of	Health a	and Me		ienę (107	146	60
	a la constant		1. Decedent's Name (First, Middle, Last)						Date of Dea Month	h Day	Year	3. Time of	Death
	Physici /Medi		Betty Ann	Brooks					April 2		007	6:45	A M
	Examir		4a. Facility Name (If not institution, give str	eet and number)		4b. City, Town,	or Location o	of Death		4c. Cou	unty of Death		
			27837 Waller Road				sbury			Wic	comico		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las.		If Under 1 Yea Months Day		24 Hrs. Min.	8. Date of Birth (Month, Day	Year)	9. Birthp	lace (State o	r Foreign
М.	Director		220-32-8754	^{1 2} M ^F 69	Yrs.				1/9/19			laware	
	and w		Usual Residence of Decedent 10a, State 10b, County	10c. City, 7	Town or Lo	cation		_			1	0d, Inside Cit	tv Limits
	Aaryli eho	ō			sbury							1 🗆 Yes	
	158.1	ect	Maryland Wicomico) Sall	Soury	10f. Zip Code			1	Og Citizen	of What Cour	ntry?	
	death with the Maryland ms 23a or 28a-f ehow Limust be notified at	Funeral Director				2180			į '	USA		iti y :	
	ns 23	era	27837 Waller Road	. Was Decedent Ever in U.S.	13. \			gin? (Spec	ifv Yes or No-		ace - Americ	an Indian.	
_	r itar	臣	1 □ Never Married 2 X Married	Armed Forces? 1 ☐ Yes 2 ▼No	I	Was Decedent of f Yes, specify Cu	ban, Mexican	, Puerto F	lican, etc.)	1	Black, White,		
0500-C	urs a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1□Yes 2⊠ N	o Specify:			Spe	ecity: Whi	.te	
5	2 ho	ted	15. Decedent's Educa		6a. Deced	lent's Usual Occ	upation			16b. Kind o	of Business/In-	dustry	
<u>''</u>	hin 7	ple	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4or 5+)	life. l	kind of work don DO NOT use retii	e during mosi red)	t or workin	g				
7	or th	Completed	12		Hous	sewife				Domes	stic		
2	al Hy d oth	Be (17. Father's Name (First, Middle, Last)				18. Mothe	r's Name	(First, Middle, i	Maiden Sun	name)		
yland	Ment Ment arka	2	Walter Hunter Wha	arton, Sr.			Ida	a Edr	a Hudso	on			
Mar	and and in man		19a. Informant's Name/Relationship (Type			g Address (Stree				-		Code)	
≥ .	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Hygiene. Department of Health and Houre. Department of Health and Hea		Willie Ray Brooks,			37 Walle	r Rd.,						
O	of Ho		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Ren	com	e of Dispo etery, cren	sition (Name of natory or other p	lace)	Da	ite	20c. Location	on - City or To	wn, State	
Daltimor	Pag ment ent: i		4 Donation 5 Other (Specify)	Coke	sbury	7 Cemete	ry '	4/22/	′07	Georg	getown,	DE	
	pparti		1. Sig. ature of Funeral Service Licensee		22	Name and Add	ress of Facility	al Ho	ome Prot	fessio	nal As	sociat	ion
0	20 E 2 9		Marie 94, Wor	MONOMO CESP	5	01 Snow	Hill	ka.,	Salisbu	ry, N	D 2180	4	
			23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	tions that caused the death. I cause on each line.	Do not ent	er the mode of d	ying, such as	cardiac or	respiratory arr	est,		Approximate Interval Bety	ween
	Physician		Immediate Cause (Final disease or condition	CHE								Onset and D	Death
	/Medical		resulting in death)	Due to (or as a consequer	ice of):						_		
	Examiner		Sequentially list conditions	Myocar	dial	Induc	non						
	D #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequer	ice of):	V							
	certificate be executed rding physicien and use as the burial-transit	am	that initiated events										
2	e exe	Ě	resulting in death) Last	Due to (or as a consequen	ice of):								
000	ate b hysic the b	llcal	d										
Ď	ing p	Mec	IF FEMALE:										
Š	ath ce ttend or use	an/	23b. Was decedent pregnant in the past 12 months?	. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de	ath 3	Ectopic pregnan	су			1	Date of delive	,	/ear
-	the a	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of deat 9 Unknown	h 5□	Other (specify)					WOTET	Day	oai
	Physicien: The law requires thet the death certifica this certificete has been signed by the attending phy rail director, page 2 should be detached for use as the	Physiclan/Med	Part II. Other significant conditions contri	husing a global hus not necessitate	and the state of the	death in a second			OZ- Dida-	1			
ń	res ti signe	þ	Tarrii oriei signinean conditions contin	butting to death but not resulting	ig in the ur	idenying cause g	jiven in Parti.		1 □ Ye	/	contribute to th	ably 4 ⊟U	
corus,	neen :	Completed	- Jeans	*9								abiy 4 🖂	
2	s law	nple							24a. Was a autops	y	b. Were auto prior to co	psy findings a ripletion of ca	available ause of
<u> </u>	The cete I	S							perform 1 ☐ Yes 2		death?	2□ No	
	clen: ertific ector,	Be	25. Was case referred to medical examiner?	20.1				of Death	(Check only on	Θ)			
5	hysi this c	မ	TU Fes Ziz NO			1 3LI DOA			e 51 Reside			/)	
5	ing P	e c	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	lb. Time of Injury	W	ork?		3d. Describe ho	w injury oc	curred		
200	tend leath tor: / the f	cat	2 Accident investigation 3 Suicide 6 Could not be				∏Yes 2 □N						
<u> </u>	fter of All files	Certification:	4 Homicide determined	 Place of Injury - At home building, etc. (Specify) 	, farm, str	eet, factory, office	9	21	Bf. Location (St City or Town	reet and Nu n, State)	ımber or Rura	I Route Numi	ber,
_	To the Hospitel or Attending Physicien: The law requir within 24 hours attended. To the Funerel Director: After this certificete has been s gompletely filled in by the funeral director, page 2 should		20a Cadillar 450 and 5	ion. To the last of	4 1								
	Hoe 24 ho Fund Fund tely f	Medical	29a. Certifier 1 Certifying Physic (Check only 2 Medical Examine one)	ian: To the best of my knowle r: On the basis of examination	age, death and/or inv	n occurred at the restigation, in my	time, date and opinion, deat	d place, ar th occurre	nd due to the ca d at the time, d	ause(s) and ate and plac	manner as store, and due to	ated. the cause(s))
	thin the mple	Med	29b. Signature and title of certifier	and manner stated.			nse number				ned (Month,		
	K H E H					250. 200	.50	`	(. Date sig	This	ay, rear)	
	192		// //	~		リ	UUSL	610	1		1/4	3/	
	0/2	(30. Name and address of person who com	pleted cause of death (Item 23	a) (Type,		Straine	Jar	rah	218	201		
	- C4-		31. Date filed (Month, Day, Year)	32. Registrar's Signature	ute	(0)	Jans	my	m		-		
	Sta	ne l		San Tolerand Salgitature	-	.0		· ·					

State Registrar

1466

-5	Physic /Medi Exami	ical
	uneral irector	
Maryland	a-f show ified at	tor

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

St. Regist

	1 - For Stete Registrar	State of War	-	Certificate of		ivicinal riy	Reg. No		V 1	\$ 8 ,	
	Decedent's Name (First, Middle, La	st)				2. Date of De	eath		(3. Time of D	Death
an :al	KEITH	OLIVER		BUNTING		4	Da		co 7	1045	М
er	4a. Facility Name (If not inatitution, give	0 10 1	01	4b. City, Town,	or Location of Deat	h		. County of		`	
Ш	Peninsula Region		Center		bury			N/Con			
	222-60-8237	Sex 7. Age (in yrs. last birtl	hday) If Under 1 Yea Months Days			1 , 1	964	Coun	place (State or htry) AWARE	Foreign
	Usual Residence of Decedent 10a. State 10b. County	1	0c. City, Town	or Location					1	0d. Inside City	Limits
ō	DELAWARE SUSSE	v	CET	BYVILLE						1 □Yes	2 🔀 No
rec	10e. Street and Number	Λ	255	10f. Zip Code			10g. Cit	tizen of Wh	at Coun	itry?	
<u>=</u>	36962 HUDSON RO	AD		199	975			USA			
ner	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	13. Was Decedent of	Hispanic Origin? (S	ipecify Yes or No	0-	14. Race	Americ White,		
Be Completed by Funeral Director	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No		to ritoan, etc.)		Specify:		HITE	
pleted	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	16a. I	Decedent's Usual Occ (Give kind of work don life. DO NOT use retir	e during most of wo	rking	16b. K	and of Busi	ness/Ind	dustry	
mo;	12	College (1-401 5+)	7	VINYL SIDI	IG INSTAL	LER		CONST	ruc	TION	
3e C	17. Father's Name (First, Middle, Last)			18. Mother's Nar	me (First, Middle	, Maider	Surname))		
Tol	OLIVER	W. B	UNTING		DORIS		EVA	NS			
	19a. Informant's Name/Relationship (19b.	Mailing Address (Stree	et and Number or Ri	ural Route Numb	er, City	or Town, S	tate, Zip	Code)	
	LORRI D. BUNTING	:/WIFE		962 HUDSON	ROAD, SE						
	20e. Method of Disposition 1		cemeter	Disposition (Name of y, crematory or other p. EORGES CEME		Date 25/07		ocation - C		own, State DELAW	JARE
	21. Signature of Funeral Service Lice	13/2		22. Name and Add		OME CEI	_				
	23a.Pan Enter the disease, or com	polications that cause th	e death Do n	HASTINGS]		-		وظللا	DE.	Approximate	
	23a. Pari Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final	_		P.			arrest,			Interval Betwo	reen
	disease or condition resulting in death)	- · · · · · · · · · · · · · · · · · · ·		r of mul	Tiple tro	wma			-	30 W	47
		Due to (or as a o	onsequence o	1);							
Jer	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a c	consequence o	f):							
ami	Cause (Disease or injury that initiated events	C									
edical Examiner	resulting in death) Last	Due to (or as a o	consequence o	f):							
dice	•	d							_		
	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf	pregnancy					23d. Date	of delive	erv	
sicial	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1∐Live birth 2 4∏Pregnant at tir 9∏Unknown		3 □Ectopic pregnar 5 □ Other (specify)	cy			Mont			ear
Phy	Part II. Other significant conditions	contributing to death but i	not resulting in	the underlying cause of	iven in Part I	23e Did	tohacco	use contrib	ute to th	ne cause of de	ath?
Be Completed by Physician/M			Tot roodining in	The anaenymy eases g				/		ably 4 □Ur	
plet						24a. Was		24b. We	ere auto	psy findings av	vailable use of
Som							ormed?	de	ath?	2 □ No	
Be (25. Was case referred to medical examiner?	Hen-Heli			26. Place of Dea	ath (Check only	one)				
To	1 Ves 2 No	Hospital:		patient 3 DOA		lome 5□Res				y)	
ion	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day)		ijury W	ury at ork? ☐ Yes 2 No	28d. Describe	-	ry occurred	1		
icat	2 Accident investigatio 3 Suicide 6 Could not b	1110107		700 1				nd Number	or Bura	ıl Route Numb	ner .
ertif	4 ☐ Homicide determined	building, etc.		m, street, factory, offic		City or To	wn, State	e)			01,
al C	29a. Certifier 1 ☐ Certifying PI	hysician: To the best of	my knowledge,	, death occurred at the	time, date and place	Deer Run e, and due to the	cause(s	and man	ner as si	tated.	
Medical Certification:	(Check only 2 Medical Examone)	miner: On the basis of e and manner state	xamination and d.	d/or investigation, in m	opinion, death occ	urred at the time	, date an	d place, an	d due to	the cause(s)	
Ň	29b. Signature and title of certifier			29c. Lice	ise number		29d. Da	ate signed	Month,	Day, Year)	
	(shul			H	30447		4	190	7		
	30. Name and address of person who							•			
	Chris Snyder	100 E. Car	2115+	DAlisbur	y Md. E	21801					
te ar	31. Date filed (Month, Pay, Year) APR 2 3	2007 32. Figistrar's	s Signature	Salisbur	, ,						

			riease	State of Maryla	nd / Dena	artment of	Health and N	Mental Hydie	ne Legible.	
			1- State Registrar	/19707EDB;700R	Cei	tificate of	f Death	Raa	2007	14662
			Decedent's Name (First, Middle, Last		^			2. Date of Death		3. Time of Death
	Physici /Medi		Larry Do	arnell	Ceph	as		Apr:1	Day 2000	7 10:15 PM
	Examir		4a. Facility Name (If not Institution, give			4b. City, Town,	or Location of Death		4c. County of Dea	
			5. Social Security Number 6. Si	Street	(ant hinth day)	If Under 1 Yea	bridge If Under 24 Hrs.	O Date of Bigh	Dorche	
	Funeral Director			M 2□F	(1 Yrs.	Months Days	s Hours Min.	8. Date of Birth (Month, Day, Y June 3	ear) Co	thplace (State or Foreign ountry)
	ō.		Usual Residence of Decedent					June 3	1731 /016	aryland
	Maryland f ehow	_	10a, State 10b. County		ity, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
3	the Mi	ecto	MD DOVCH 10e. Street and Number	ester	Canb	101. Zip Code			000	
2	a or	Funeral Director	ino. Street and Number	-1 1				109	. Citizen of What Co	ountry?
	death ms 23	era	11. Marital Status	12. Was Decedent Ever in I	U.S. 13. V		6/3 Hispanic Origin? (Spiban, Mexican, Puerto	pecify Yes or No-	14. Race - Ame	
ဖွ	or ite	F	1 Never Married 2 Married	Armed Forces? 1 ☑Yes 2 ☐ No 4/ If Yes, Give	112	fYes, specify Cu I□ Yes 2⊡K No		Rican, etc.)	Black, Whit	te, etc.
5-0036	urel',	Completed by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates: 8/	75				Specify: Blo	zcK
	n 72 h	lete	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. Deced	lent's Usual Occi kind of work don OO NOT use retir	upation e during most of worl red)	king 16	b. Kind of Business	/Industry
2121	within iene.	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	Tru				ounty Go	vernuent
	a filed other	BeC	17. Father's Name (First, Middle, Last)		1.00	C/5		ne (First, Middle, Ma		VE V PIMEVII
ylai	2 should be filed withir and Mental Hygiene. Is marked other then sumatic event, the Ms	5	Weetay	O. Cepha:	S		Mary	Virginio	Pinde	r_
Maryland	2 sho		19a. Informant's Name/Relationship (7	Гуре, Print)	19b. Mailin	g Address (Stree	et and Number o Ru			
	ss 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other then "neturel", or Items 23s or 28s-f ehow other traumatic event, the Medical Examinar must be notified at		20a. Method of Disposition	phas	Place of Dispo	High S		ubridge 1	VIOYY/AN c. Location - City or	
Baltimore,	ages of of of t: # it		1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, cren	natory`or other pl	lace)			
İ	permit. Pages Department of Important: If I eny Injury or once.		4 □ Donation 5 □ Other (Specify 21. Sign sture of Funeral Service Licen			n CeMe			ambridge	e, maryland
ä	permit. Departrimports eny inj.		Janelle	C. Henry) 1	IN WAS	ress of Facility une Rai H Shington	St. Cam	oridae. I	MD 21613
			23a. Pas Enter the disease, or comp	plications that caused the a	th. Do not ente	er the mode of dy	ring, such as cardiac	or respiratory arrest	27	Approximate Interval Between
4	Physician		23a. Pay Enter the disease, or companies, or heart failure. List only of Immediate Cause (Final disease or condition	Hemato	celluli	ur Gur	ano ma			Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as a conse		1				
	Examine:	ē	Sequentially list conditions,	b. Due to (or as a conse	nuance off:					
	uted d ansit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	220 10 (0) 20 2 201100						
oʻ	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Exa	resulting in death) Last	Due to (or as a conse	quence of):					
3760,	ate be nysicia he bu	Ical		, d						
89 x	entifica ing ph e as t	Physiclan/Medl	IF FEMALE:							
Вох	attend for us	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregr	tal death 3 🗌	Ectopic pregnan	су		23d. Date of de Month	livery Day Year
P.O.	that the de ned by the a detached f	ysic	1 □ Yes 2 □ No 9 □ Unknown	4☐ Pregnant at time of 9☐ Unknown	death 5	Other (specify)				
	signed by	by Pt	Part II. Other significant conditions of	ontributing to death but not re	sulting in the ur	nderlying cause g	even in Part I.	23e. Did tobac	co use contribute to	the cause of death?
Records,	w requires been sig should b	ed b	Circhosia					1 ☐ Yes	2 □ No 3 □ Pr	robably 4 Unknown
ဝ၁	law re as be 2 sho	Completed	Menotitis	C				24a. Was an autopsy	24b. Were at	utopsy findings available completion of cause of
Œ	The ate h	E O						performe	d? death?	2 No
/ita	cian: sertific ector,	Be	25. Was case referred to medical examiner?	Manager I.		10		th Check only one	•	
of Vital	Physician: rthis certifica ral director, p	5	1 ☐ Yes 2 No 27. Magner of eath		ER/Outpatien 28b. Time of	3 DOW		ome 5 Residence 28d. Describe how		cify)
5	ding h. After fune	盲	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	28c. Inju	ork? □Yes 2□No	200. Describe now	injury occurred	
Division	Atten r dea ector by the	≝	3 Suicide 6 Could not be determined	28e. Place of Injury - At I	home, farm, stre			28I. Location (Stree		ural Route Number,
ā	tel or rs efte al Dir ed in	Certification:	4 - Homelde	building, etc. (Spec	ary)			City or Town, S	state)	
	To the Hospitel or Attending Physicien: The law within 24 hours effect death. To the Funeral Director: Affect this certificate has completely filled in by the funeral director, page 2	S S	(Check only 2 Medical Exam	ysician: To the best of my kn niner: On the basis of examin	owledge, death	occurred at the	time, date and place,	and due to the caus	e(s) and manner as	s stated.
	thin 2 the the	Medical	29b. Signature and title of certifier	and manner stated.			nse number		Date signed (Mont	
	F 3 F 8) and	MM	A	D(9()	51822	(04/19/	07
		4	30. Name and address of person who o	completed cause of death (Ite	m 23a) (Type, I	Print)	CV A		216	13
_				dmally mil	, 5	oi byen	St. Co	moriage	, MO -2	1543
	Sta Registr		31. Date liled (Month, Day, Year)	32. Registrar's Sign	nature	N 10 0				

			For State Registrar	State of Ma	arylan				ealth a Death		•	giene Reg. No			14663
	Physici	an	1. Decedent's Name (First, Middle, Las Letie G. Cam	pbell							2. Date of De Month	ath Da	y Y	ear	3. Time of Death
	/Medio	-	4a. Facility Name (If not institution, give	<u> </u>			4b. Cit	, Town, or	Location o	of Death	04	2	0 20 (County of	-	6:38 a ^M
	L X d l I M l	ाट। ः	Agape Assisted L	ivina			Н	iatts	ville			P	rince	Geo	raes
	Funeral Director		5. Social Security Number 6. S		e (In yrs. 71	last birthday) Yrs.	If Und Month	or 1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of Bir (Month, Da June 19	th			place (State or Foreign
pur	3155		Usual Residence of Decedent 10a, State 10b, County		10c. Cit	v. Town or Lo	cation							1	0d. Inside City Limits
Maryl	e pa	ioi	NY			Bron									1 X Yes 2 □ No
the l	r 28a	Director	10e. Street and Number			DIOIL		ip Code				10g. Ci	tizen of Wh	at Cour	ntry?
th witi	23a o		2368 Bruner Ave.					10	469				USA		
г два	sms Er m	Funerai	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U	.S. 13.\	Vas Dec	edent of Hi	spanic Orig	gin? (Spe	cify Yes or No Rican, etc.))-	14. Race - Black,	Americ White,	
Maryiand 21215-0056 d2 should be filed within 72 hours after death with the Maryland	hygiene. d other than "natural", or liems 23a or 28a-f show event. Its Madical Examber must be politied at	by	1 ★ Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 📆 N If Yes, Give Year or Dates:	No			2 ⊠ No	Specify:				Specify:	В1	ack
72 h	natu disal	Completed	15. Decedent's Ed (Specify only highest gra			16a. Deced (Give	kind of v	rork done d	furing most	t of workii	ng	16b. K	and of Busi	ness/In	dustry
with in	than	mp	Elementary/Secondary (0-12)	College (1-4or 5	5+)			use retired				Wes	t Che	ste	r Jewish H
D D	ent.		12th 17. Father's Name (First, Middle, Last)			Nurse	es A	SSIST		er's Name	(First, Middle,				- 00112511 11
ld be		To Be	Hilton Campbell						Iris	Hil	da Gowo	lie			
Tary 2 shot	it Health and Mer stem 27 le marke othar traumatic		19a. Informant's Name/Relationship (7	Гуре, Print)		19b. Mailir	g Addre	ss (Street a	an <i>d</i> Numbe	er or Rura	l Route Numbe	er, City	or Town, St	ate, Zip	Code)
	Health tem 27 i		Linneth A. Clarke	/Daughter							w Carro				
Baltimore,	Department of H Important: If item any injury or oth once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			Place of Dispo semetery, crem Hope			į.		·2007	Has	ocation - Ci tings	or To	own, Slate -Hudson, NY
Balt	portar portar y injur		21. Signature of Funeral Service Licen		TIL.						ishall'	s Fu	ineral	2 Ho	
n a	impo any ir once.		J.P. ma	shall		4	217	9th.	St. 1	N.W.	Washin	gtor	ı, D.(2. 2	0011
//\ Ex	ysician and purial-transit the printer stransit the printer stransit the printer stransit that t	dicai Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Cancer Due to (or as b. Due to (or as c. Due to (or as d.	a conseq	uence of):			a515						
the death certific	by the attending phitached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Feta	Ideath 3∐	Ectopic Other (pregnancy specify)					23d. Date of Month		ery Day Year
ires that	speen signed by	by Pr	Part II. Other significant conditions of	ontributing to death b	ut not res	ulting in the ur	nderlying	cause give	en in Part I.						ne cause of death?
necords, he law requires t	peen	etec											1		
	s certiticate has t director, page 2 s	Completed											dea	ath?	psy findings available mpletion of cause of 2KD No
Of VICAL Physician: 1	ector	Be	25. Was case referred to medical examiner?	Hospital:				Oth			(Check only o				Assisted
o å	# ± 0	.T	1 Yes 2 No 27. Manner of Death	1 L Inpatie		ER/Outpatien 28b. Time of		28c. Injury			ne. 5 Residente. 18d. Describe I				Living
ing in	deatn. ctor: After y the funer	ation	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		y Year)	Injury	М	Work	res 2 🗆 l		.ou. Describe	iow iiiju	Ty occurred		
DIVISION tal or Attending		Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, et	ury - At ho c. <i>(Specif</i>	ome, farm, stro y)	eet, facto	ry, office		2	28f. Location (3 City or Tox	Street ar wn, State	nd Number 9)	or Rura	al Route Number,
- Hospital	within 24 hours after To the Funeral Dire completely tilled in b	Medical	29a. Certifier 1 (Check only one) 1 Certifying Ph 2 Medical Exam	ysician: To the best niner: On the basis of and manner sta	f examina	wledge, death tion and/or inv	occurre estigation	d at the time in, in my op	e, date an pinion, deal	d place, a th occurre	and due to the ed at the time,	cause(s date an) and mann d place, and	er as s	tated. the cause(s)
To the	To th comp	Me	29b. Signature and title of certifier	- (D)		ŧ		9c. License	number			29d. Da	ite signed (Month,	Day, Year)
	0			THUCK	1	M.	7	D002	4721			Apr	il 20	, 20	007
	(5)		30. Name and address of person who a Syed Akbar Sadiq,					Le RD	. Sui	te 2	08 Lau	re1	, Md.	207	708
	Sta Registr	-	31. Date filed (Month, Day, Year) APR 9. 4. 2007	32. Registra	ar's Signa	ture									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Maryland		rtment of He tificate of D		F	Reg. No.	07	14664
	Physicia /Medic		Decedent's Name (First, Middle, Last) George	Ear1ston	Carte	er	4	2. Date of Dea Month 19	-	Year	3. Time of Death 3:45 P. M
	Examin	_	4a. Facility Name (If not institution, give s 325 West Patrick			4b. City, Town, or L Frederick			4c. County Frede		
	Funeral Director		5. Social Security Number 6. Sex 213-40-3120	7. Age (In yrs. las	t birthday) Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birtl June 18	3,1942	9. Birthpl Coun Mary	lace (State or Foreign Tand
vland	at		Usual Residence of Decedent 10a. State 10b. County	10c. City, 1	Town or Loc	eation				10	0d. Inside City Limits
e Mar	8a-f sh atified	ctor	Maryland Frederick	Ija	amsvi	_			40.00		1 ☐ Yes 2 No
h with	23a or 2 st be no	al Dire	10e. Street and Number 4102 C Ijamsville	Road		10f. Zip Code 21754			10g. Citizen of V USA		try ?
5-UUSO 72 hours after death with the Maryland	to Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Y Year or Dates:		Vas Decedent of Hisp Yes, specify Cuban, □ Yes 2☐No	panic Origin? (Spe , Mexican, Puerto Specify:	cify Yes or No- Rican, etc.)	14. Race Blace Specify	e - America ck, White, e B1a	
2 P	"natur	Be Completed	15. Decedent's Edu (Specify only highest grade		16a. Deced	ent's Usual Occupati kind of work done du DO NOT use retired)	ion ring most of worki	ng	16b. Kind of Bu	ısiness/Ind	lustry
Mithin	r than the Me	dwo	Elementary/Secondary (0-12)	College (1-4or 5+)		nter			Constr	cucti	on
	and Mental Hygiene. s marked other than " umatic event, the Mer		17. Father's Name (First, Middle, Last) Herman L.	Carter, Sr		1	8. Mother's Name Marcell		Maiden Surnan owden	ne)	
should !	and Ment is markec	P	19a. Informant's Name/Relationship (Ty			g Address (Street an	nd Number or Rura	il Route Numbe	er, City or Town,	State, Zip	Code)
, Mi	Health a		Mary Lyles/ Sister			Fingerboar					
nore	nt of H		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	ternoval from State		sition (Name of natory or other place)	1	oate	20c. Location -	•	
aitimoi	Department of Important: If it any injury or conce.		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License			UMC Cemete . Name and Address					
מ פֿ	28 = 5		Koulfl	institute that accord the death		21 Opossum				ID 21	
	hysician /Medical xaminer		23a. Park. Eler the disease, of compl shock, or kear failure. List only or Immediat. Cause (Final disease or condition resulting in death)	a. Due to (or as a conseque	ed	Kidne	-	ncer	1631,		Approximate Interval Between Onset and Death Smum the
58/5U, ficate be executed	physician and sthe burial-transit	Examiner	Sequentially list conditions, if any, leading to firm offact cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to for as a consequence. Due to for as a consequence.							
5875U	physic s the b	edical		1							
. BOX	e attending d for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnand 1 ☐ Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea 9 ☐ Unknown	leath 3□	Ectopic pregnancy Other (specify)				ite of delive	ery Day Year
ecords, P.O	n signed by	by	Part II. Other significant conditions con	ntributing to death but not resulti	ing in the ur	nderlying cause giver	n in Part I.	23e. Did to			he cause of death?
r a	ate has	Completed						24a. Was autop perfo	osy ormed?	Were auto prior to cor death? 1 ∐ Yes	opsy findings available mpletion of cause of 2 Stoo
or VITA	his certificate har	o Be (25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ EF	P/Outpation	Othor	26. Place of Death	(Check only o	nne)	Car	regiver*s
on or	After this funeral di	I	27. Manner of Death 12 Natural 5 Pending 2 Accident investigation		28b. Time of Injury	28c. Injury Work?	at		now injury occur		y) Home
DIVISION Lor Attending	within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At hom building, etc. (Specify)	ne, farm, str	eet, factory, office		28f. Location (3 City or Tox	Street and Numb vn, State)	er or Rura	al Route Number,
H o	e nospire 24 hours e Funera letely fille	Medical C		sician: To the best of my knowl iner: On the basis of examination and manner stated.	on and/or in	vestigation, in my op	inion, death occur	red at the time,	date and place,	and due to	o the cause(s)
, t	withir To th	Me	29b. Signature and title of certifier			29c. License	number		29d. Date signe	d (Month,	Day, Year)
	11		30. Name and address of person who or	ompleted cause of death (Item 5	23a) (Type	Print)	100		111114	, of	.00 T
	V		Kanan Hudhud,	ND 468 Th	u ma	& Johnson	wind us	e Fr	ralen	ck	m021702
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	and manner stated. ompleted cause of death (Item 2 OD 32. Pigistrar's Signatu	lire	back					

			For State Registrar	State of Ma	aryland		artment o				giene Reg. No.	7111	17	100	565
		69	1. Decedent's Name (First, Middle, Las	t)						2. Date of De	eath			3. Time of	Death
	Physici /Medio		Irving Douglas Coc	k, Sr.						Month April	18, Day	2007	ear	6:05	\mathbf{P}^{M}
4	/Medic Examir		4a. Facility Name (If not institution, give			-	4b. City, Tov	wn, or Location				County of	Death		
May .	E AGIIII		20 East South Stre	et			Fred	lerick			Frederick				
	Funeral		Social Security Number 6. Security Number		e (In yrs. la	ast birthday)		ear If Und	der 24 Hrs.	8. Date of Bir	th av. Year)		. Birthpla	ace (State o	r Foreign
н	Director		229-34-3501	XM 2□F	76	Yrs.	Worldis	ays	J WIIII.	Oct. 13	, 19	30	Virg	ínia	
	pu ,		Usual Residence of Decedent 10a. State 10b. County		10c City	, Town or Lo	ncation						10	d. Inside Ci	by Limits
	aryla shov	_											10	1.XXIYes	-
	he M 28a-f otifie	Director	Maryland Frederic	:k	Fre	deric		-1-			10~ Cit	izen of Wha	at Count		
	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	ă	10e. Street and Number				10f. Zip Co								
	s 23e	Funeral	20 East South Str	12. Was Decedent	Cupa in 11 C	2 140	21703		Origina (Con	oif. Vac or No		nited			
	er de item ner n	ů.	11. Marital Status 1 □ Never Married 2 ★ Married	Armed Forces?		5. 13.	If Yes, specify	Cuban, Mexi	ican, Puerto	ecify Yes or No Rican, etc.))-		White, e		
36	rs aft I", or camil		3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	10		1 □ Yes 2 🗽	No Spec	lfy:			Specify:	Whi	te	
21215-0036	hour Itural	Completed by	15. Decedent's Ed			16a. Dece	dent's Usual C	occupation			16b. K	ind of Busir	ness/Ind	ustry	
5	in 72 " " na ledic	olet	(Specify only highest gra-	de completed)		(Give	kind of work o DO NOT use i	lone durina n	nost of worki	ng					
12	with iene. thar	E	Elementary/Secondary (0-12)	College (1-4or 8	0+)		Cook				F	ood S	ervi	.ce	
d 2	filed Hyg sther		17. Father's Name (First, Middle, Last)					18. Mc	other's Name	(First, Middle	, Maiden	Surname)			
lan	d be ental ked c	To Be	Carl Ernest Cook					1	Minnie	Sutph	in				
Maryland	12 should be filed within h and Mental Hygiene. 7 is marked other than ' traumatic event, the Me	H	19a. Informant's Name/Relationship (7	ype. Print)		19b. Maili	ng Address (S	treet and Nui	mber or Rura	al Route Numb	er, City o	or Town, Sta	ate, Zip	Code)	
S	nd 2 state and 2 s		Evelyn Cook / Wife	1		20 E	. South	st.,	Frede	rick,	MD 2	1701			
ō,	s 1 and 2 i Health tem 27 i		20a. Method of Disposition		20b. PI	lace of Disno	sition (Name	of	Aprif			ocation - Ci	ty or Tov	vn, State	
Baltimore,	ages ent of rt: If i		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (<i>Specif</i> y				Thaven 1 Garde		200		Fred	erick	Ма	rylan	ď
Ħ	artme artme ortan Injur		21. Signature of Experience Licen	-	110	2:	2. Name and A	Address of Fa	cility						<u> </u>
Ba	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.		1/1/			R	esthave 501 Cat	en Fund	eral S Mtn.	ervice Hwy. F	s, Si	kkot (Cody MD	2170i	
-			23a. Pa 1. Enter the disease, or his shock, or he failure. Lis nly	Dications that caused	the death							r r c ic ,		Approximat	е
		П	Immediate Cause (Final											Interval Bet Onset and I	ween Death
	Physician /Medical		disease or condition resulting in death)	a. Lung Ca		ioneo of):							M	onths	
	Examiner			Due to (or as	a consequ	ierice or).									
		-	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. — Due to (or as	a consequ	ience of):							-		
	ited insit	Examiner	cause. Enter Underlying Cause Unisease of Injury that initiated events										- 1		
	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the buriat-transit	xai	resulting in death) Last	Due to (or as	a consequ	ience of):							\top		
8760,	siciar buri	dical E		d											
687	ficate phys s the	be		u.											
Box	leath certifica attending ph I for use as t	Physician/Me	IF FEMALE: 23b, Was decedent pregnant	23c. If yes, outcome								23d. Date	of delive	ry	
ă	eath atte	ciai	in the past 12 months? 1 □ Yes 2 □ No	1□Live birth 4□Pregnant a			⊒Ectopic preg ⊒ Other (spec					Month	1	Day	Year
O.	at the de by the	ıysi	9 Unknown	9□Unknown											
4	that led b		Part II. Other significant conditions of	ontributing to death b	ut not resu	alting in the u	nderlying caus	se given in Pa	art I.	23e. Did	tobacco	use contrib	ute to th	e cause of o	leath?
ds.	uires tha signed Id be del	d b	Chronic Obstructi	ve Lung D	iseas	e				128	Yes 2	□ No 3	☐ Proba	abiy 4 □	Jnknown
Records,	> 0 0	Completed by	Atherosclerotic H	leart Dice	200					24a. Was	s an	24h We	re autor	sy findings	available
Re	e la has je 2	E			450					auto	psy ormed?	prid dea	or to con ath?	npletion of c	ause of
ā			Diabetes Mellitus 25. Was case referred to medical	Type II						1 Yes	2 ☑ No	1 1 _	Yes	2 □ No	
Σ	Physician: this certificanal director,	Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	0 TI	ED/Outratia	nt 3□ DOA	Othor		(Check only		о Пои:	(0)		
Division or Vital	Physral di	- To	27. Manner of Death	28a. Date of Inju	iry	28b. Time o		 -		me 5X Res 28d. Describe			., ,	"	
on	Attending r death. ector: After oy the fune	Certification:	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	y Year)	Injury	м	. Injury at Work? 1 ☐ Yes 2			,				
S	Vtten deat ctor: y the	ica	3 Suicide 6 Could not be	28e. Place of ini	ury - At ho	me, farm, st	reet, factory, o	ffice		28f. Location	(Street ar	nd Number	or Rura	Route Nun	nber,
<u>S</u>	after Dire	ertii	4 ☐ Homicide determined	building, e	tc. (Specify	()				City or To	wn, State	9)			
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,			ysician: To the best											
	e Ho 24 h e Fur etely	Medical		niner: On the basis of and marrier st	of examinat										s)
	To the within To the Comp!	Me	29b. Signature and title of certifier	/11		944	29c. L	icense numb	er	T	29d. Da	ite signed (Month, I	Day, Year)	
	F > F 0) / Ann	11	_	1	() D 1	L6428			Apri:	1 20,	200	7	
	n i		30. Name and address of person who	completed sause of	leath (Item	23a) (Tyne	Print)				•				
	V		Casper Cline, M.I					cick, 1	MD 217	01					
1	St	ate	31. Date filed (Month, Day, Year)	32. egist	rar's Signa	ture	barde								
			NDD 9 2 2	118 / 1 Frank	42.1 1	Cr M	A STATE OF THE PARTY OF THE PAR								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. -1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** JOHN **JOSEPH** APRIL 21, 2007 12:03P M CROWLEY /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner LAPLATA r 1 Year | If Under 24 Hrs. CIVISTA MEDICAL CENTER CHARLES 8. Date of Birth (Month, Day, Yea, NOV 16, 1 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 9. Birthplace (State or Foreign **Funeral** Days Hours 1**X** M 2□ F MASSACHUSETTES Yrs. 83 018-14-1055 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show r 28a-f show notified at 1 ☐ Yes 2 X No Director MARYLAND CHARLES BRANDYWINE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 2 16352 WOODVILLE ROAD 20613 UNITED STATES Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. r than "naturai", or items the Medical Examiner mu Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify. þ Specify: 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **ENGINEER** DEPT. OF DEFENSE permit. Pages 1 and 2 should be filed Department of Health and Mental Hygir Important: If item 27 is marked other any injury or other traumatic event, <u>if</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JOHN J. CROWLEY MARY CAHALANE 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BRIAN P. CROWLEY - SON 16352 WOODVILLE ROAD, BRANDYWINE, MD 20613 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State APRIL Burial 2 Cremation 3 ☐ Removal from State ST. MARY'S CH. CEM. 4 Donation 5 DOther (Specify) 26, 2007 PISCATAWAY, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M00053 HUNTT FUNERAL HOME 3035 OLD WASHINGTON RD., WALDORF, MD 20601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician 45 minutes disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Esquerdially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseque Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician s the burial Physician/Medical attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy certificate 24 No the Hospital or Attending Physician: 25. Was case referred to medical examiner?
Yes 2□ No funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 □ DOA 1 Inpatient Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural
2 Accident 5 ☐ Pending investigation To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Medical Center of death (Item 23a) (Type, Print) 30. Name and address of person who 31. Date filed (Month, Day, Year) State APR 2 4 Registrar

CROWLEY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 14667 For State Ragistrar Certificate of Death Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year amper 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death + Dorche Ster 9. Birthplace (State or Foreign Country) reet 6. Sex 1 M 2 ☐ F 5. Social Security last birthday) Months Days Min. Hours 46-Yrs. Maryland 10b. County 10c. City, Town or Location 10d. tnside City Limits 1 THE 2 TINO 1 1

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. important: if item 27 is marked other than "naturel", or items 23a or 28e-1 show empty ijury or other treumatic event, the Madical Expurime must be notified at once. Baltimore, Maryland 21215-0036

1-

10a. State

Physician

/Medical

Examiner

Funeral

Director

Physician /Medical Examiner

> physician and s the burial-transit attending pl certificate has been signed by the irector, page 2 should be detached : After this co within 24 hours after death.
>
> To the Funeral Director: A completely filled in by the fu

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

ctor	MD Dorch	rester (rank	ric	lae				1 Pres 2 No
Funeral Director	10e. Street and Number 704-Pine	Street	Apt. 1	10f. Zip Cod	1613		10g. (Citizen of What C	ountry?
une		12. Was Decedent Ever in U. Armed Forces?	S. 13. Was	Decedent on s, specify C	of Hispanic Origin? Juban, Mexican, Pue	(Specify erto Ric	y Yes or No- an, etc.)	14. Race - Am Black, Whi	
2	1	1 Yes 2 12 No If Yes, Give Year or Dates:	1 🗆	Yes 201	No Specify:			Specify: B1	acK
Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Decedent (Give kind	d of work do	ne during most of w	vorking	16b.	Kind of Business	s/Industry
d E	Elementary/Secondary (0-12)	College (1-4or 5+)	1	NOT use re			0.		0
0	17. Father's Name (First, Middle, Last)		Lawn	_Ma	18. Mother's N		irst, Middle, Maid		Residence
o O	Charles	Henry C	amper	r Sr	La	10	Car	nish	
	19a. Informant's Name/Relationship (Typ		19b. Mailing A	dd ess (Str	et and Number or I	Rural R	oute Number, City	or Town, State,	Zip Code)
	Dellyne	Camper	7146	ree		AVE	· Cam	bridge	MD.21613
	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re		lace of Disposition emetery, cremator	n (Name of ary or other)	olace)	Date		Location - Sity A	Town, State
1	4 Donation 5 Other (Specify)	Ch	rist Rock	CeMe-	lery 14	125	107 Co	Mbride	e, Maryland
	21. Signature of Funerat Service License	. Henri	1 22. Na He 51	me and Ad NRY UWa	funera Shingt	1 /-	tome, P. St. Cam	Ai bridge	, MD. 21613
	23a. Part1 Enter the disease, or complice shock, or heart failure. List only on	cations that caused the death e cause on each line.	Do not enter the	ne mode of	tying, such as cardi	ac or re	spiratory arrest,	J/	Approximate Interval Between
	tmmediate Cause (Finat disease or condition resulting in death)	Dil	ated	Co	rdiom	40	perthe	1	Onset and Death
	resulting in dealing	Due to (or as a consequ	uence of):						
5	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	uence of):						
	cause. Enter Underlying Cause (Disease or injury that initiated events		, i						
E Ya	resulting in death) Last	Due to (or as a consequ	uence of):						
Medical	L d.	·							
Me	tF FEMALE:								
all	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1□Live birth 2□Fetal 4□Pregnant at time of de	death 3 Ect	opic pregna				23d. Date of de Month	livery Day Year
33	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	ain 5 Oir	ner (specify)					
7	Part II. Other significant conditions conf	tributing to death but not resu	ulting in the under	lying cause	given in Part I.		23e. Did tobacco	use contribute to	o the cause of death?
ב כ						.	1 🗆 Yes	2 ŪMO 3 □ P	robably 4 Unknown
200							24a. Was an	24b. Were a	utopsy findings available
5							autopsy performed? 1 ☐ Yes 2 ☐	death?	completion of cause of
מ	25. Was case referred to medical examiner?					eath (C	heck only on		
2	TEL TES ZEPAG			_ 00A	Other: 4 Nursing		5 UH sidence		ecify)
	27. Manne of Death 1 □ atural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of tnjury		jury at Vork? □ Yes 2 □ No	28d.	. Describe how in	ury occurred	
	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, street,	factory, office	ce ·	28f.	Location (Street a City or Town, Sta		ural Route Number,
incal .	29a. Certifier 1 Certifying Physic (Check only one)	ician: To the best of my knower: On the basis of examinat and manner stated.	wledge, death occion and/or investi	curred at the gation, in m	time, date and plac y opinion, death occ	ce, and curred a	due to the cause at the time, date a	s) and manner a nd place, and du	s stated. e to the cause(s)
	29b. Signature and title of certifier			29c. Lice	nse number		29d. C	ate signed (Mont	th, Day, Year)
	BPaltron	1'D		Do	05704	10	04	1/20/2	2007
ļ	30. Name and address of person who cor	- 4	23a) (Type, Print			*			f

State Registrar

105 istrar's Signature Aurora Street Cambridge, MD 21613

PALTOD

23

			Fleas	State of Ma						
			For State	State of Ma	aryland / Dep	partment of e <i>rtificate of</i>			. 211117	14.568
			Registrar 1. Decedent's Name (First, Middle, I	.ast)		Timoato or	Deam	2. Date of Deat		3. Time of Death
	Physici		Doris Eliz	abeth Carte	r			April 2	0, ^{Day} 2007 Year	11:15 a M
	/Medi Examir		4a. Facility Name (If not institution, g			4b. City, Town,	or Location of Death	~	4c. County of Deat	
			32020 Tuckahoe	Avenue			Cordova		Talbo	t
	Funeral	2	,	Sex 7. Age	O /. Yrs.	/) If Under 1 Year Months Days		8. Date of Birth (Month, Day,	Year) 9. Birt	hplace (State or Foreign untry)
	Director		214-22-0385 Usual Residence of Decedent		84 Yrs.			April 11	L, 1923 Mai	ryland
١	land w		10a. State 10b. County		10c. City, Town or I	_ocation				10d. Inside City Limits
L	Man a-f sh	tor	Maryland Harfo	ord	Ha	avre de G	race			1 □ Yes 2 🗹 No
X	atter deeth with the Marylar or iteme 23a or 28a-f show immer must be notified at	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	untry?
EL	23a		100 Hopkins Rd.			210			U:	SA
1	teme	Funerai	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S. 13	. Was Decedent of If Yes, specify Cul	Hispanic Origin? (Sp ban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □ Yes 2 ☑ X If Yes, Give Year or Dates:	ło	1 ☐ Yes 2 ☑ No	Specify:		Specify:	
8	2 hou	ed	15. Decedent's	Education	16a. Dec	edent's Usual Occu	pation		Wh: 16b. Kind of Business/	
215	I within 72 ho iene. r than "natu the Medical	plet	(Specify only highest	grade completed) College (1-4or 5	(Giv	e kind of work done DO NOT use retir	during most of work ed)	ing		,
21	ygiene Agiene er tha	Completed	Elementary/Secondary (0-12)	2	Sec	cretary			State Gov	vernment
pu	d oth	Be	17. Father's Name (First, Middle, La	•			18. Mother's Nam	•	•	
₹	2 should be filed within 72 hours after death with the Maryland and Mantal Hygiene. is marked other than "natural", or iteme 23a or 28a-f ahow is marked other than "natural", or iteme 29a or 28a-f ahow aumatic event, the Medical Examinat must be notified at	2	Frederick Pembr					lizabeth		
Maryland 21215-0036	s 1 end 2 should be filed f Health and Mental Hyg item 27 is marked othe other traumatic event,	p i	19a. Informant's Name/Relationship Cheryl LaVerne Lo				oe Ave., (City or Town, State, 2 MD 21625	(ip Code)
	Health tem 27		20a. Method of Disposition	/3comb/ badgi		position (Name of ematory or other pla		-	20c. Location - City or	Town, State
2	Pages nent of I nt: if it	l î	1 Burial 2 Cremation 3 4 Donation 5 Other (Spe				nCenter 4/	/21/2007	Cambridg	⊵e. MD
Baltimore,	골 분론증·		21. Sgnature of Funeral Service Lice	A						
ä	Depa Impo		Millen Too	ran /son	Mexel.	nd Shore 272 Huds	on Rd., Ca	n Center ambridge	P.O. Box MD 2161	3
		-	23a Part 1. Enter the disease, or co shock, or heart failure. List on	mplications that caused by one cause on each lin	the death. Do not e.	nter the mode of dy	ing, such as cardiac	or respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	/	lage los					Onset and Death 4-2075
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):	-				. 1
		70	Sequentially list conditions,	b. Due to (or as	consequence of):	gu				years
	uted I Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dem		SPENCEL OF	iv due	and		year
ć	sicien and buriat-transit		that initiated events resulting in death) Last	Due to (or as a	consequence of):		0000			
1760	Hospital or Attending Physicien: The law requires that the death certificate be executed 4 hours after death. Funeral Director: After this certificate has been signed by the attending physicien and lety filled in by the funeral director, page 2 should be detached for use as the burial-transit	cal	,	d						
89 3	leath certificate t attending physi	by Physician/Medi	IF FEMALE:							
Вох	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth	2 Fetal death 3	□Ectopic pregnanc	су		23d. Date of del Month	ivery Day Year
	that the deatt ed by the atte detached for	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□ Pregnant at 9□ Unknown	time of death 5	Other (specify)				,
P.0	that if	F.	Part II. Other significant conditions	contributing to death bu	ut not resulting in the	underlying cause g	ven in Part I.	23e. Did tob	acco use contribute to	the cause of death?
Division of Vital Records,	w requires t been signe should be	q p	avenue					1 □ Ye	s 2□No 3□Pr	obably 4 Minknown
Ö	aw rec s bee	Completed	Sewinday	Kelperke	esa this	reden	\	24a. Was an	24b. Were au	topsy findings available completion of cause of
æ	The lav	E						autopsy perform	ned? death?	completion of cause of
ita	ysicien: is certifice director, p	Bec	25. Was case referred to medical examiner?				26. Place of Deat		9)	
<u>></u>	hysic this ce	은	1 ☐ Yes 2 ☑ No	-	nt 2□ER/Outpatio	BILL 3 LI DOA			nce 6 Dother (Spec	nter's home
Ë	ding Ph. After thi funeral	i o	27. Manner of Death 1 ☐Naturat 5 ☐ Pending	28a. Date of Injur (Month, Day	y Year) 28b. Time Injury	We		28d. Describe ho	w injury occurred	
isio	death. ctor: A y the fu	ficat	2 Accident investigat 3 Suicide 6 Could not	be Oca Otaca of Injur	ıry - At home, farm, s]Yes 2□No	28f. Location (Str.	eet and Number or Ru	ıral Route Number.
Ρį	after after Dire	Certification;	4 ☐ Homicide determine	building, etc	. (Specify)	moon nationy, comoc		City or Town	State)	
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director:		29a. Certifier 1 Certifying (Check only 2 Medical Ex	Physician: To the best of	of my knowledge, dea	ath occurred at the t	ime, date and place,	and due to the ca	use(s) and manner as	stated.
	the Hin 24 the Fu	Medicai	one) 2 Medical Ex	aminer: On the basis of and manner sta	ted.	nvestigation, in my	opinion, death occur	red at the time, da	ite and place, and due	to the cause(s)
	To To E	Σ	29b. Signature and title of certifier				se number		d. Date signed (Monti	_
			Sim) 00 4602	D	4/28	(0)
			30. Name and address of person wh Syed Ishrat Ali,	M.D., 505A	Dutchman	's Lane.	Easton M	D 21601		
	Sta	ete	31. Date filed (Month, APR 2	32. Restra	ar's Signature	J Daile /	Lascon, M.	D 21001		
	Registi		APK 23	2001	me de	Sports				

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month 04 5:05PM 2007 20 /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Wicomico 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) Funeral Min. 1 □ M 2 💢 F 7-35 Director 28-4506 filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show 1 Yes 2 No Director POCOMOKE ORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 No 3 Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be ESSIE NAE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type 9515-OLD PRINCESS ANNE KD WESTOVER (=UMBY-MURRAY-DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or 1 Burial 2 □ Cremation 3 □ Removal from State POCOMOKE, MD JAMES UMC 28 4 Donation 5 Dother (Specify) EM! 07 BENNIE SMITH FIM 21. Signature of Euneral Service 22. Name and Address of Facility any POCOMOKE CITY, MD 21851 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CARCINOMA LUNG /Medical Due to (or as a consequence of) Examiner ARDIOMYO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the burial-transi attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 ☐ Yes 1□ Yes To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 ☐ Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 70 After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? Natural Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DO058410 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COASTAL POBOF# 1733 SALISBURY HOSPILE WAR attuam 31. Date filed (Month, Day Year) Registrar's Signature State Registrar APR 24 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

Physician
/Medical
Examiner

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Queen E.	Dunawa	ay				April	24,	2007	7:33A ^M
er 4a. Facility Name (If not in	stitution, give stree	et and number)		4b. City, Town, or	Location of Death		ļ,	. County of Death	
Southern	Maryland	d Hosp	ital	Clin	iton		Pr	ince Ge	eorges
5. Social Security Number 226-18-12	4 🗆 14		(In yrs. last birthday 85 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D	ay, Year)	Cou	
Usual Residence of Deced	lent								
	County		10c. City, Town or L	ocation					10d. Inside City Limits
DC 10e. Street and Number			Wash	ington					1 XYes 2 No
10e. Street and Number				10f. Zip Code			10g. Citi	izen of What Cou	ntry?
620 Morto	n Stree	t, NW		200	1.0		Uni	ted Sta	ates
620 Morto	12. \	Was Decedent E Armed Forces? 1 □ Yes 2K N	ver in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba		pecify Yes or No Rican, etc.)	0-	14. Race - Americ Black, White,	
3 XWidowed 4 □ D	ivorced	f Yes, Give Year or Dates:		1 ☐ Yes 2 XXNo edent's Usual Occup	Specify:		1ch V	Specify: B	lack
(Specify only Elementary/Secondary	ecedent's Education of highest grade con (0-12)	mpleted) College (1-4or 5-	(Giv	e kind of work done of DO NOT use retired	during most of work)	king	100. Ki	and of business/in	loustry
Unknown				<u> Housewif</u>				rivate	
17. Father's Name (First, i					18. Mother's Nam		e, Maiden	Surname)	
David G. I	Nicholas	S			Jenny	Jones			
19a. Informant's Name/Re Herbert Du			806	ing Address (Street a Kayak A itol Hei	lvenue			or Town, State, Zij	o Code)
20a. Method of Disposition			20b. Place of Disc	osition (Name of	-	Date 20		ocation - City or T	own, State
1 Strial 2 □ Cren 4 □ Donation 5 □ C	nation 3 □Remo ther (<i>Specify)</i>	oval from State	Resurre	ematory or other place ction Ce	m. 5/2/		Cl	inton,	Md.
21. Signature of Funeral S	Service Licensee	UTUL	. /	2. Name and Addres		-			
23a. Art/ Enter the dise shrick, or heart failul Immediate Cause (Final disease or condition resulting in death)	_ a	796		iter the mode of dyin					Approximate Interval Between Onset and Death
Sequentially list conditions that leading 1. In the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c		consequence of):						
IF FEMALE: 23b. Was decedent pregn in the past 12 month 1 Yes 2 Palo 9 Unknown	s?	if yes, outcome p 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)				23d. Date of deliv Month	ery Day Year
Part II. Other significant of	onditions contribu	uting to death bu	t not resulting in the	underlying cause give	en in Part I.		tobacco u		he cause of death?
Completed						24a. Was auto perf	psy ormed2	prior to co	opsy findings available empletion of cause of
	modical				00.00	1□ Yes	2 No	1 ☐ Yes	2 A No
25. Was case referred to examiner?	medical Hospi	ital: . —		nt 3D DOA Othe	26. Place of Deat				
Yes 2 No 27. Manner of Death		1 ☐ Inpatier		III. 3 DOA	4 LI Nursing He			6 □Other (Special	fy)
1 Natural 5 2 Accident	Pending investigation	(Month, Day	Year) 285. Time Injury	Worf	y at ⟨? Yes 2 □ No	28d. Describe	now injur	ry occurred	
1 Natural 5	Could not be determined	8e. Place of inju building, etc	ry - At home, farm, s . <i>(Specify)</i>	reet, factory, office		28f. Location (City or To	Street an wn, State	nd Number or Run e)	al Route Number,
	ortifying Physicis	n: To the best o	f my knowledge, dea	th occurred at the tin	ne, date and place	, and due to the	cause(s)) and manner as s d place, and due t	stated.
29a. Certifier (Check only one)	ledical Examiner:	On the basis of and manner sta		nvestigation, in my o	pinion, dodin occu				.0 110 04400(0)
(Check only one) 29b. Signature and title of	certifier	On the basis of and manner sta	ted.	29c. License	e number			te signed (Month,	Day, Year)
(Check only 2 M	certifier	On the basis of and manner sta	ted.	29c. License	e number				Day, Year)

ORIGINAL

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No./ 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2007 21, DAVID CLIFTON DAWSON April 9:00 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Homewood at Crumland Farms Frederick | If Under 1 Year | II Under 24 Hrs. | 8. Date of Birth | North | Days | Hours | Min. | Nov. 3 , 1979 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Mary Tand 80 219-22-3358 Director Usual Residence of Decedent fited within 72 hours after death with the Maryland 10a State 10h Count 10c. City, Town or Location 10d. Inside City Limits or 28a-f ehow the Medical Exertiner must be notified at MD Frederick Frederick Director 1 ☐ Yes 2 ☐ No 10g. Citizen of What Country? U.S.A. 10e. Street and Number 10f. Zip Code 21702 7351 Willow Rd. Cottage # "neturel", or Itema 23a by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ NoWWII If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖫 No Specify. Specify: WHite 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education ify onfy highest grade completed) 16b. Kind of Business/Industry (Specify only highest parmit. Pages 1 and 2 should be filed within Department of Health and Mantal Hygiana. Important: If Item 27 is marked other then eny injury or other traumetin. Elementary/Secondary (0-12) College (1-4or 5+) Theology Minister of the Gospel 6 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Jesse P. Dawson Blanche Armstrong 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7351 Willos Rd Cottage #4 Frederick, Md. 21702 Patricia A. Dodson/wife 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Smithsburg Crematory 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal Irom State 4 ☐ Donation 5 ☐ Other (Specify) 4-23-07 SMithsburg. 21. Signature of Funeral Service Licenses ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 23a, Part1, Enter complications that caused the Approximate Interval Between Onset and Death No disease beath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Due to (gras a consequence of): Examiner ugen Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760. the attanding physician Physician/Medical as tha IF FEMALE USB 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 0 in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.O. datachad 9 Unknown 9 Unknown ል Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed paga 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cartificate 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: funaral diractor Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 vursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending daath. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funarel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) fillad in by 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title-of certifier 29c. License number 10+ Th SI; Frederik, Md 17201 16001) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

07-03265 Terry Easton Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ry Easton	State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No.												
Physicia dical Exami	an/	Decedent's Name (First, Midd Terry B. Eas						2. Date of Dea Month April 28, 2	ith Dav Year	3. Time of Death 2042 hrs			
•		4a. Facility Name (if not institution Western Maryland He		,		b. City, Town, Cumberla	or Location of and	Death	4c. County of Allegany	Death			
Funeral Director		5. Social Security Number 212–68–3871	6. Sex 7	. Age (In yrs. Ia	ast birthday) Yrs.	If Under 1 Y Months D	ear If Under ays Hours	Lin		h(MM/DD/YYYY) 9. Birthplace (State or Foreign Maryland Country)			
nd show any ice.	7.	10a. State MD Alle	gany		Town or Location			II.		10d. Inside City Limits 1 Yes 2 X No			
the Maryland 3a or 28a-f show	Director	10e. Street and Number 901 Seton Dri	ve			10f. Zip Code	21502	1	10g. Citizen of Wha USA	t Country?			
pure formulation of the street and Number of the street and Number of the street of th									No- White, etc. Specify: White				
5-0036 iled within 72 hours Hygiene. I other than "natur	Completed I	15. Decedent's Education (Spe Elementary/Secondary (0-12)	College (1-4		during mo	st of working I	ife. DO NOT u Carpent	er d	16b. Kind of Busi				
21215-003 uld be filed withi Mental Hygiene. marked other tt	To Be Co	17. Father's Name (First, Middle Charles Ernes 19a. Informant's Name/Relations	t Easton		19h Mailing	Address (St	Mary	Name (First, Middle, C. (Beeman) Easton				
	_	Mary C. Bower	s M		115 B]	Lackist	on Ave	., Cumberl	and, MD				
Baltimore, permit. Pages I and Department of Heal Important: If item injury or other tra	-	1 X Burial 2 Cremation 4 Donation 5 Other S 21 Signature of Funeral Service	pecify:			vn Mem		s May 2, 0					
Medical	23a. Part I. Enter the disease, or complicatives that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate												
Examiner		Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	Due to (or as a c		f):			14 14		Death			
ted 	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that influeted events resulting in death) Last	Due to (or as a c	200-0				•					
O, e be executed ysician and burial - transit	ledical	X UNPENDED	AMENDED PI	I,27,28a	-f, perME	, G868,	6/19/07	TT	Look Bir die				
Aecords, P.O. Box 68760 The law requires that the death certificate to cate has been signed by the attending physipage 2 should be detached for use as the but	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Uni	ne 1 Live bir	th nt at time of de	2 Feta		-	pregnancy	23d. Date of d Month	Day Year			
s, P.O. E ires that the d is signed by the	ğ	Part II. Other significant condit	ions contributing to c		-	nderlying caus	e given in Part			ute to the cause of death? Probably 4 Unknown			
	Completed							1 🗸 Yes	psy pri prmed? de	ere autopsy findings available or to completion of cause of ath? Yes 2 No			
Vital Inysician: this certif	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No	Hospital: 1 ✓ Int	patient 2	ER/Outpatient		Other	Check only one) Nursing Home 5	Residence 6	Other:			
ion fendii eath.	Subject fell												
Division To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu	27. Matural 5 Pending Investigation 3 Suicide 6 Could not be determined Homicide Homicide Homicide Specify Nursing Home 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
To the Hospital within 24 hours a To the Funeral completely filled	Medical	(Check only Certifying P	hysician: To the best on miner: On the basis of and manner sta	examination a									
FAFO	Ĕ	29b. Signature and title of certifie		6			ense number C.M.E.		29d. Date signed May 1, 2007	(Month, Day, Year)			
		30. Name and address of person Ling Li, MD Assista	who completed cause nt Medical Exam		^{23a)} Penn Street	, Baltimore	e, MD 2120)1					
St Regist	ate rar	31. Date filed (Month, Day, Year)	2007 32 Reg	strar's Signatu	A Con	0		· · · · · · · · · · · · · · · · · · ·					

DHMH 17 Rev 1/2001 OCME 2006)7-02910 Kara Sı

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 14673

ara Sue Erwin	1-	For State eqistra Americ#7 PerFHPCC4_24_	OZ Certifica	ate of	Death				g. No.		3. Time of	Death
Physicia		. Decedent's Name (First, Middle,Last)					2.1	Date of Death Month April 16, 20	Day 007	Year	1205	
Med camin		Kara Sue I a. Facility Name (if not institution, give street	Erwin and number)	41	b. City, Town, o	Location of			4c. Co	ounty of Dea		
	Н	1920 Lakewood Street			Suitland If Under 1 Ye	ar If Under	24Hrs. 8	. Date of Birt	1		Birthplace (St	ate or
Funeral		. Social Security Number 6. Sex	7. Age (In yrs. last bir	thday) Yrs.	Months Da		Min.	03-20-	-1948	For		ndiana
Director		311 40 2321	₩ F 58 59	110.								de City Limits
any		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	n or Location	on						1	es 2 No
* .		Maryland Prince Geor	ge's	Suit1					O= Citizor	n of What C	country?	
te Maryland or 28a-f show fred at once.	Director	10e. Street and Number			10f. Zip Code]			,	
th the Maryland 23a or 28a-f shon notified at once.		1920 Lakewood Stre	et	1 - 144	20740 as Decedent of I	Jienanic Orio	in? (Spec	ify Yes or No		JSA 4. Race - An	merican Indiar	n, Black,
eath with items 23 ust be no	eral	11. Marital Status 1 Never Married 2 * Married A	Was Decedent Ever in U.S. Armed Forces?	13. vva	es, specify Cub	an, Mexican,	Puerto Ri	can, etc.)		White, etc		
r death wi or items	Funeral		Yes 2 ※ No Give Year		Yes 2 🛪					,,	Mite	
rs after ural", miner	à	Widowed 4 Divorced if Yes, pr Dai 15. Decedent's Education (Specify only high		a. Deceder	nt's Usual Occu	ation (Give	kind of wo	rk done d)	16b. Kir	id of Busine	ess/Industry	
2 hour	completed	Elementary/Secondary (0-12)	college (1-4 or 5+)						Cin	aular	Wirel	000
5-0036 fled within 7 Hygiene. I other than the Medica	du	12th	+04	Custo	mer Ser	VICE K	r's Name (1	First, Middle,	Maiden S	urname)	MITE	.633
5-0 iled w Hygie Jothe the h	ပ္ပို	17. Father's Name (First, Middle, Last)				Tm	nogeni	e Smit	h			
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once	o Be	Charles R. Miller 19a. Informant's Name/Relationship (Type, F	Print)	19b. Mailin	ng Address (Si	reet and Nur	mber or Ru	ıral Route Nu	ımber, City	or Town, S	State, Zip Coo	de)
MD 2 Id 2 shoul Ilth and M m 27 is m	ř	Robert Erwin/husbar	nd []	1920	Lakewoo	d Stre	eet	Suitla Date	nd, Mo	ocation - Ci	40 ity or Town, S	tate
e, K and 2 Health item 2		20a. Method of Disposition 1 * Burial 2 Cremation 3 R	20b. Plac	e of Dispo natory or o	osition (Name of other place)		1					
nor ages ant of a		1 Donation 5 Other Specify:	Ceda	r Hil	1 Cemet			3-2007	Su	itlan	a,Ma.	
Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filted within 72 hours after Department of Health and Mental Hygiene. Titem 27 is marked other than "natural". Immortant. If it firm 27 is marked other than "natural".		21. Signature of Funeral Service Licensee	IMAIZIC	/ 22.	Name and Add	ess of Facili	, 111	DΛ Δνε	S11	itlan	d.Md.2	0746
0		23a. Part I. Enter the disease, or amplication	ons that caused the death. Dr	o not enter	the mode of dy	ng, such as	cardiac or	respiratory a	arrest, sho	ck, or heart	Appr	oximate Inter veen Onset a
sicia: edica		failure. List only one cause on each in	ntact Gunshot Wound									Death
Examine		Immediate Cause (Final disease a. CDF or condition resulting in death)	to (or as a consequence of):	BI Olice								
		Sequentially list conditions, b										
	iner	INIO	to (or as a consequence of):									
	Examine	(Disease or injury that initiated events resulting in death) Last	to (or as a consequence of):									
tal Records, P.O. Box 68760, cian: The law requires that the death certificate be executed certificate has been signed by the attending physician and	al E		MENDED									
60, ate be ex ohysician	Medical	UNPENDED	23c. If yes, outcome of pregna	incy					23	d. Date of d		Year
876 ificate ng phy	N E		Live birth	2	Fetal death	3 Ecto	pic pregna	incy		Month	Day	Teal
Box 687(e death certifica	sicia	1 Yes 2 V No 9 Unknown	Pregnant at time of deat	in 5	Other (Specify							
Bo Bc	Physician/	Part II. Dther significant conditions con		sulting in th	ne underlying ca	use given in	Part I.				bute to the car Probably	
P.O.	b detac	7									Vere autopsy	
ds, equire	ould b			_				a	Vas an utopsy erformed?	рі	rior to comple leath?	etion of cause
Division of Vital Records, ra or Attending Physician: The law requiring a store death. an Director. After this certificate has been s	Completed										✓ Yes	2 N
Re n: The	funeral director, page				26	Place of Dea			Davis	dense 6 M	Other: Scer	ne.
Vita hysician this cer	directo	1 Yes 2 No	T	ER/Outpat		c. Injury at W		ing Home 5	ribe how ir	njury occurre		
of ving Ph	uneral	27. Mariner of Death	28a. Date of Injury (Month, Day Year) Apr 16, 2007	28b. Time 0000 hrs		Yes 2		Subject	shot sel	f		
ion ttendi death.	y the f	2 Accident Pending Investigation	28e. Place of Injury - At ho	me, farm,	street, factory, o	ffice building	g, etc.	28f. Locat	ion (Street	and Number	er or Rural Ro	oute Number
lor A	filled in by the fund	3 Suicide 6 Could not be determined	(Specify) Single Fam	nilv						treet, Suitl		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Function: After this certificate has been signed by the attending physician.	ely fille		n: To the best of my knowledg		occurred at the t	me, date an	d place, ar	nd due to the	cause(s)	and manner place, and c	r as stated. due to the cal	ıse(s)
thin 2	mplet	one) 2 Medical Examiner: C	on the basis of examination ar and manner stated.	nd/or inves	sugation, in my	License num					ned (Month, E	Day, Year)
C S S S	2	29b. Signature and title of certifier	~ 11		290.	O.C.M.E.				pril 17, 20		
. 1		30. Name and address of person who co	moleted cause of death (Item	1 23a)								
CRIG		30. Name and address of person who co Susan Hogan MD. Assist	ant Medical Examiner	111	Penn Stree	, Baltimoi	re, MD 2	21201				
7	Sta		32. Registrar's Signatu	ad	ブ							
Re	gistr	HER GALLOVI /	HARLES - F									

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar 1. Decedent's Name (First, Middle, Last)	State of Iviary	•	rtificate of			Reg. No.	U /	3. Time of Death
	Physicia /Medic	_	FRANCES L'	FUNK				Month	Day 29	Year	7:48
	Examin		4a. Facility Name (If not institution, give st JHHCC 333	reet and number) Mill St.		HAGE	RSTOW			nty of Death	afon
	Funeral Director		011000101	M 2 XF 7. Age (In	yrs. last birthday, Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da February	th 28,1915	Cour	place (State or Foreig htry) V
Post Marriage	Ba-f show	ector	Usuel Residence of Decedent 10a. State 10b. County MD		c. City, Town or L	-K		10d. Inside City Lin 1 ☐ Yes 2 ☒ 10g. Citizen of What Country?			
di di	23a or 2 ust be n	Funeral Director	13934 Orchard	RIÓGE	SD	10f. Zip Code	10		-	SA SA	itry !
ally latted within 70 boung after door with the Manifold	The fifth and Mental Hygiene. It has the marked other than "natural", or Items 23a or 28a-f show other traumatic event, It a Modical Examiner must be inclined at	by	11. Marital Status 1 Never Married 2 Married 3 Wildowed 4 Divorced	2. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	r in U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	Е	lace - Americ Black, White, cify: W	
2 - 2 - 3 - 2 - 3 - 3 - 3 - 3 - 3 - 3 -	iene. r than "natu	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	(Give	dent's Usual Occup a kind of work done DO NOT use retired	pation during most of work d)	sing	16b. Kind of	Business/In	dustry
	and Mental Hygiene. Is marked other than sumatic event, Ita M.	Be	17. Father's Name (First, Middle, Last)		TION	Indiscr	18. Mother's Nam			ame)	
y is	marke marke	To	Frank S. Fox 19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mail	ing Address (Street	and Number or Rui	n Kesec		vn, State, Zip	Code)
֓֞֞֜֞֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓			Dollie A. McCarty/I				c St. Hag				
	nent o ant: If ury or		20a. Method of Disposition 1 ▼Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	moval from State	orchard I	matory or other plan Ridge Cem	. 05/04		Hancoc		
0	Departr Importu any inju		21. Signature of Funeral Service License	1		2. Name and Addre	ess of Facility ral Home,	141 Wes			
	hysician and businian as the prival-transit	Medical Examiner	23a. Part 1. Enter the disease of complice shock, or heert failure. List only one immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		onsequence of):	ary f yrold	Irtery	019	SRQS	2	Onset and Death
O. DOX O	riystciat. The taw requires triat the death continue. this certificate has been signed by the attending I ral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of p 1□Live birth 2□ 4□Pregnant at tim 9□Unknown	Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у		1	Date of delive	ery Day Year
olds, r	n signed by	þ	Part II. Other significant conditions cont	ributing to death but n	ot resulting in the	underlying cause giv	ren in Part I.		obacco use c Yes 2 □ No		he cause of death?
וו חפכם	ate has bee page 2 sho	Completed						24a. Was auto perfo	psy ormed?	b. Were auto prior to co death? 1 \(\sum \text{Yes} \)	opsy findings available mpletion of cause of
VILA	certific irector,	o Be	25. Was case referred to medical examiner? 1 Yes 2 Ho	ospital:	2 FB Out-sti-	Ot	26. Place of Dear			200	
NISIOII O	ath. r: After this ie funeral d	ertification: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 28a. Date of Injury (Month, Day Ye	2 ER/Outpatie	of 28c. Injur		ome 5 Resi 28d. Describe			у)
בובר בובר בובר	in the hospital or actioning within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certific	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (S	At home, farm, si Specify)	treet, factory, office			Street and Nu wn, State)	mber or Run	al Route Number,
	within 24 hours after to the Funeral Directory Completely filled in	edical	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examin	cian: To the best of mer: On the basis of exand manner stated	amination and/or is	th occurred at the tinvestigation, in my	me, date and place, opinion, death occur	, and due to the rred at the time,	cause(s) and date and place	manner as s ce, and due t	tated. o the cause(s)
	within To the compl	Me	29b. Signature and title of certifier	when		29c. Licens	se number	6	29d. Date sig	ned (Month,	Day, Year)
	6		30. Name and address of person who cor	npleted cause of death	(Item 23a) (Type SMED	, Print)	-6 U	Pal	C+W.	D 21	742
Ì,	Sta Registi		31. Date filed (Month, Day, Year)	32, Registrar's	Signature	Cack D	Hadas	*	/		

FORREST

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Reg. No.

2007

20

2. Date of Death Month April

4675

3. Time of Death

6:46 p M

Physician
,
/Medical
Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural," or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at annes.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

ıer	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death 4c. County o								
	Southern Maryland Hospital			lint	on			P	rinc	e Ge	eorges
	5. Social Security Number 262-28-1551 6. Sex 1 □ X M 2 □ F 86	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bin (Month, Da May 8	h V. Year 19	20	_ Co	hplace (State or Foreign untry) Orgia
	Usual Residence of Decedent 10a. State 10b. County 10c. City	y, Town or Lo	notion								404 1-11-00-11-0
_											10d. Inside City Limits
cto	DC Wa	ashing	ton								1X∑Yes 2 No
ire	10e. Street and Number		10f. Zip	Code				10g. Ci	tizen of V	What Co	untry?
E .	4406 Kansas Ave. N.W.			200	11				U	ISA	
Jer	11. Marital Status 12. Was Decedent Ever in U.	S. 13. 1	Was Dece	dent of Hi	spanic Ori	igin? (Spe	ecify Yes or No Rican, etc.)		14. Rac	e - Ame	rican Indian,
Ē	Armed Forces? 1 □ Never Married 2 □ Married 1 □ 1 □ 1 □ No		If Yes, spe	cify Cuba	n, Mexicai	n, Puerto	Rican, etc.)		Blac	ck, White	e, etc.
Completed by Funeral Director	1 Never Married 2 Married 1		1 ☐ Yes	2 [3 No	Specify:				Specify	y: B2	lack
etec	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usua kind of wo	al Occupa	ation <i>during m</i> os	t of worki	ina	16b. K	(ind of Bu	usiness/	Industry
du	Elementary/Secondary (0-12) College (1-4or 5+)		kind of wo DO NOT us)		9		16 7		
Ö	12th	Mas	ter B	aker				Se	1f E	mplo	oyed
3e (17. Father's Name (First, Middle, Last)				18. Mothe	er's Name	e (First, Middle,	Maider	Surnan	ne)	
To Be	Marshall Forrest					Emma	Tart				
_	19a. Informant's Name/Relationship (Type, Print)	19b, Mailir	ng Address	(Street a	and Numb	er or Rura	al Route Numb	er. City	or Town.	State, 2	Zip Code)
	Margaret D.Neale/Niece		U Nea dywin)613	al Route Numb	,,			
	20a. Method of Disposition 20b. P	Place of Dispo					Date	20c. L	ocation -	City or	Town, State
	I M Buriai 2 Cremation 3 Removal from State	. Linc			1	4-28-	2007	Bre	ntwo	od.	MD.
	21. Signature of Funeral Service Licensee						Home, In		11000	, ,	
	> S. P. Marshall						Home,II Nashingt		D. C		20011
	23a. Part Enter the disease, or complications that caused the death show, or heart failure. List only one cause on each line.								2.0		Approximate interval Between
			- 1	/ 7	- E	4.					Onset and Death
	disease or condition resulting in death)	Myoc	gruin	0	war	vicer	1				
	Due to (or as a consequ	uence of									
_	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of the conditions)	uonaa of):									
Physician/Medical Examiner	cause. Enter Underlying Cause (Disease or injury	derice oi).									
xar	that initiated events c. Due to (or as a consequence of the constant of the co	uence of):									
a		,								ļ	
dic	d										
/Me	IF FEMALE: 23c. If yes, outcome pf pregna	n n ou									
ian	in the past 12 months?	death 3	Ectopic pr						23d. Da	te of del	ivery Day Year
sic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time or d	eath 5	Other (sp	ecify)					1410	,,,,,,,	Day real
h	9 ☐ Unknown										
>	Part II. Other significant conditions contributing to death but not resu	uiting in the u	nderlying c	ause give	en in Part I		23e. Did t			tribute to	the cause of death?
Completed b							1 🗆 '	Yes 2	₩ No	3 🗌 Pr	obably 4 Unknown
Jet							24a. Was	an	24b.	Were au	rtopsy findings available
Щ							auto _l perfo	rmed?	. !	prior to o death?	completion of cause of
ŭ	OF Man and a state of the state						1□ Yes	2 - N	0	1 🗌 Yes	2 4 10
To Be	25. Was case referred to medical examiner?			Othe	or.		n (Check only o				
L	1 Inpatient 2	ER/Outpatier)A	4 ⊔ Nt		me 5 Resid				cify)
on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, Day Year)	28b. Time o Injury		8c. Injury Work			28d. Describe I	now inju	iry occur	red	
cati	2 Accident investigation 3 Suicide 6 Could not be 280 Place of injury At he		М		Yes 2□	-					
TĘ.	4 Homicide determined 28e. Place of injury - At he building, etc. (Specific	ome, farm, str y)	eet, factory	, office			28f. Location (3 City or Tox	Street a vn, Stat	nd Numb e)	er or Ru	ural Route Number,
ပိ											
Medical Certification:	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my kno 2 Medical Examiner: On the basis of examina and manner stated.	wledge, deat tion and/or in	h occurred vestigation	at the tin	ne, date ar pinion, dea	nd place, ath occur	and due to the red at the time,	cause(s date an	s) and ma nd place,	anner as and due	s stated. e to the cause(s)
ME	29b. Signature and title of sortifier			. License	_			29d, Da	ate signe	d (Mont	h, Day, Year)
	Kha my			D00	05512	0		Ac.	1/ 2	20	7005
	30. Name and address of person who completed cause of death (Item	1 23a) (Tvpe	Print)					7	1 ~		
	Richard Palmen his 1328 Southern	n avenu	L 58	Since	te 3	10 1	Jishung ho	~ D	C 2	0232	_
ate	31. Date filed (Month, Day, Year) 32. Registrar's Signa	iture		-			1				
rar	APR 2 4 2007 Face D. A.	per									

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 255P M CARRIE Μ. FRAZIER 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S HOSPITAL CENTER CHEVERLY PRINCE GEORGE'S If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 KF 81 Yrs. Director 579-28-1612 11/16/1925 REMBERT. S.C. Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "neture!; or items 23e or 28a-1 ehow other traumatic event, the Madical Examinar must be notified at Director PRINCE GEORGE'S CAPITOL HEIGHTS 1 Yes 2 □ No MD10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10+ 1207 ADDISON RD. #463 20743 UNITED STATES death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hyglene. Important: if item 27 is marked other then "neturer; or item eny Injury or other traumatic event, the Mental series and 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th SUPERVISOR DRY CLEANING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be STAFFORD LEE HELEN SANDERS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JEROME FRAZIER/ SON 602 GARNER AVE., WALDORF, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State tX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) GLENWOOD CEMETERY 4/28/07 WASHINGTON. D.C. 21. Signature of Juneral Service Licen 22. Name and Address of Facility CAPITOL MORTUARY INC. 1425 MARYLAND AVE., N.E. WASH., D.C. 20002 23a. Parti. Enter the disease, or shock, or heart failure. List on plications that caused the death. Do parenter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) rneumonia /Medical Due to (or as a consequence of) Examiner hrence Obstructive Lung Disease if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine attending physicien and for use as the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Dav 4☐Pregnant at time of death 5 Other (specify) been signed by the s should be detached t ☐ Yes 2 ☐ No 9k Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an performed? Yes 22 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No filled in by the Director: 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of 29d. Date signed (Month, Dey, Year) D55220 who completed cause of death (Item 23a) (Type, Print) 30. Name and ladd 3001 ervi Cheverly MO HOSP DR 32. Registrar's Signature 31. Date filed (Month, Day, State APR 2 4 200 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April Physician Kouan Fong 2007 6:30 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ellicott City 2719 Dunleer Road Howard 5. Social Security Number If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, 1)

June 4, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**X** M 2□ F Days ^{Year)} 1915 China 330 28 3136 91 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside Cify Limits r 28a-f show notified at 1 ☐ Yes 2 No Director MD Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a or dical Examiner must be 2719 Dunleer Road 21042 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2**K** If Yes, Give Year or Dates 2**K** No 1 Never Married 2 Married 1 ☐ Yes 2X No Specify. ģ Specify: 3 Widowed 4 □ Divorced Asian Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrical Engineer General Electric R & D 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unknown unknown ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jason Fong/Son 250 South Presidents St. #308 Baltimore, MD 21202 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Injury or 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Nother (Specify) entombment Gate of Heaven Cem. 4-24-2007 Silver Spring, MD 21. Signature of Funeral Service Licensee M01044 22. Name and Address of FacilityHarry H. Witzke's Family FH Inc. any 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final tr/eriose disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, the to for an eleganous offi Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? 2**4** No 1□ Yes Be 2

Physician /Medical Examiner

physician

certificate

this After the funeral

in 24 hours the Funeral Dires.

within 24

or Attending Director; Certification:

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Department of Health Important: If item 27 other t

Pages '

be executed

Box 68760.

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Division or Vital Records,

72 hours after

Baltimore, Maryland 21215-0036

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25. Was case refer examiner?	red to medical	26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)									
1 ☐ Yes 2√	No										
 Manner of Deat 1 Natural 2 Accident 	5 Pending investigation		28b. Time of Injury	М	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred					
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of injury - At he building, etc. (Specif	ome, farm, street, fy)	facto	ery, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a Certifier	1 XCertifying Ph	vsician: To the best of my kno	wledge death oc	curre	d at the time, date and place	and due to the cause(s) and manner as stated					

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifie Mr. /www

29c. License number

29d. Date signed (Month, Day, Year) April 23, 2007

Glen Burnie md 21060

Name and address of person who completed cause of death (Item 23a) (Type, Print)

115 Jober Koesler istrar's Signature

31. Date filed (Mont 2007



State

Registrar

			For State	State of	Marylan		rtment of H				1/ 145/8
	Registrar 1. Decedent's Name (First, Middle, Last)								Reg. No. 2. Date of Death 3. Time of Death		
	Physicia /Medic		Evelyn		G	arlitz			Apr 29	, 20007	2:30pm ^M
	Examin		4a. Facility Name (If not institution, give street and number) Devlin Manor Nursing Home				4b. City, Town, or Location of Death Cumberland			4c. County of Death Allegany	
Ī	Funeral Director		5. Social Security Number 6. S 215-26-7138	Sex 7. □ M 2□xF	Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day) May 4,	-	Birthplace (State or Foreign Country)
			Usual Residence of Decedent 10a. State 10b. County			y, Town or Lo	antion				10d. Inside City Limits
	shov	٥	MD Allega	ny	100.01	Frost					1 ☐ Yes 2 ☐ No
	15e h	rect	10e. Street and Number				10f. Zip Code		1	0g. Citizen of Wh	nat Country?
	permit. Pages 1 and 2 should be lied within 72 hours eiter death with the Maryland Depertment of Health and Menial Hygiene. Depertment of Health and Menial Hygiene. Important: If them 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, it a Medical Examinar must be notified at once.	Funeral Director	72 Mels Road					US	USA		
		ner	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in Amed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		s?	U.S. 13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P		spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		American Indian, White, etc.
20		by Fu			GIVE I		□Yes 2 No		Specify: white		
-000	2 hour	led t	15. Decedent's Education 16a.			16a. Deced	Decedent's Usual Occupation (Give kind of work done during most of working			16b. Kind of Business/Industry	
2	thin 7.	Completed	(Specify only highest gr Elementary/Secondary (0-12)	completed) College (1-4	or 5+)	life. L	OO NOT use retired,)	_		
7	led wi		Elementary/Secondary (0-12)	1		Dietar	/ Departm	18. Mother's Nam			l Hospital
200	Mental H rked oth	To Be	17. Father's Name (First, Middle, Last Roy Burns	,					Wilhelm		,
Mary	and 2 sho alth and h 127 is ma sr trsums		19a. Informant's Name/Relationship (Diane Jolley		ughter		g Address (Street a Sbury Avenu		ral Route Number LaVal		MD 21502
Поге	Pages 1 a ent of Hes nt: If itsm ry or othe		20a. Method of Disposition 1			cemetery, cren	sition (Name of natory or other place norial Park		5/2/2007	20c. Location - C Cumber	rland MD
pairimor	permit. Depentration imports any injury.		21. Signature Pineral Service Lice	nsee ///	M	22	Name and Address Scarpell	i Funeral H ninia Avenu		land MD 2	1502
			23a. Pan L Enter the disease, or com- mock, or heart failure. List only	phoations that cau	sed the deat	h. Do not ente					Approximate Interval Between
ı	Physician /Medical Examiner		Immediate Cause (Final disease or condition CHRONIC RENAL INSURFICIENCY								
			resulting in death)	0.11	as a consec						
		-	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Juence of):	W						
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2/00	death certificate be executed e attending physicien and id for use as the burial-transit	dical	•	d							
õ ×		Med	IF FEMALE:	23c. If yes, outco	ma of progra	2001			· · · · · · · · · · · · · · · · · · ·		1
X Q	eath c attend for us	Physician/Me	23b. Was decedent pregnant in the past 12 months?	uldeath 3□	Ectopic pregnancy Other (specify)			23d. Date Mont			
j.	the d	hysi	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknow							
r V	requires thet the een signed by th hould be detache		Part II. Other significant conditions	contributing to dea	th but not res	sulting in the ur			23e. Did tobacco use contribute to the cause of death?		
ğ	equire sen sig	Completed by	CHR. DIAR	proids	Sm	1 Yes 2 No 3 Probably 4 Unknown					
Hecords,	e 2 sh	npie							24a. Was a autops	sy pri	ere autopsy findings available for to completion of cause of
	n: The licete he									2 X No 1	ath? ☐Yes 2☐ No
NIT OF	siciar	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 XNo	Hospital:	atient 2	ER/Outpatien	Othe		th <i>(Check only or</i> ome 5 ☐ Resid		(0
5	To the Hospital or Attanding Physician: The law requires that the death certific within 24 hours after death. To the Funast Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as it.	n: To	27. Manner of Death	28a. Date of	Injury	28b. Time of				ow injury occurred	
<u> </u>		atio	1 Natural 5 Pending 2 Accident investigation	n	Day Year)	Injury		Yes 2 □No			
DIVISION		Certification:	3 ☐ Suicide 6 ☐ Could not to determined	289. Place 0	f Injury - At h , etc. <i>(Speci</i>	ome, farm, stre fy)	eet, factory, office		28f. Location (S City or Town		r or Rural Route Number,
		edical C	29a. Certifier (Check only one) Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check only one)								
		2	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5/1/07								
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NOSHIN QAISRANI — MI) 47 VIRGINIA AVE. CUMBERUAND MI) 21502 31. Date filed (Month, Day, Year) 32 Segistrar's Signature								
			31. Date filed (Month, Day, Year)	A AVE	sistrar's Sign	UNBE	RUAND	11(1)	21502		
4.	Sta Registi		MAY 0 7	0007	Total o oigh	B do	ale				
			MAIUC	UUI PORTO	Care a	1					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 1, 2007 **Physician** Esther Mae Galliher 5:19 P ^M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner WMHS-Frostburg Nursing & Rehab Ctr Frostburg Allegany If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Jun 28, 1923 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** MD Director 83 215-44-9133 should be filed within 72 hours after death with the Maryland and Mental Hygiene.

s marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If them 27 is marked other than "natural", or frems 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at Oldtown 1 ☐ Yes 2 ☐ No MD Allegany Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21555 USA 18401 Forsythia Hill Way Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 X No 1 ☐ Yes 2 ☐ **X**o Specify: Completed by 3 ₩ Widowed 4 Divorced white 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Un. of MD Ext. 12 Extension Aide 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked Susan Speelman Miller Ernest Miller ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 is m Cumberland MD 21502 Rebecca Zoller daughter 411 Avirett Avenue 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Xurial 2 □ Cremation 3 □ Removal from State 5/4/2007 WV Asbury Cemetery Baker 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Scarpelli Funeral Home, PA 21. Signature any In 108 Virginia Avenue: Cumberland, MD 21502 Fact. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Discore Immediate Cause (Final Physician Covonm disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Ence Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed for use as the burial-tran attending physician and Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 🗷 No Month detached 9 ☐ Unknown ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by s been signe should be d bornative 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed: certificate 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Medical Certification: To Be Other: 45 Aursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 | Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After (Month, Day Year) 5 Pending 1 ☐ Yes 2 ☐ No ours after death.
neral Director: A
filled in by the fu investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital within 24 hours a (c) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

4

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Registrar

State

Broadway

gistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32.

Jesus H.

31. Date filed (Month, Day, Year)

D21244

Frostburg, Md

21532

Months

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

7. Age (In yrs. last birthday)

72

Reg. No.

Physician	
/Medical	
Examiner	

1 Decedent's Name (First Middle Last) Luther

5. Social Security Number

217-28-6052

Gladhill. .Tr. 2. Date of Death April 21,2007 3 Time of Death 5:08AM M

9. Birthplace (State or Foreign

MaryTand

4a. Facility Name (If not institution, give street and number) Northampton Manor Health Care

1**X** M 2□ F

4b. City, Town, or Location of Death Frederick

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Aug 8, 1934

4c. County of Death Frederick

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be presented.

Saltimore, Maryland 21215-0036

Physician /Medical Examiner

The law requires that the death certificate be executed attending physician and for use as the burial-trar been signed by I should be detact page 2 s certificate this

Division or Vital Records, P.O. Box 68760,

Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits Maryland Frederick 1 ☐ Yes 2 🙀 No Director Thurmont 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 11054 Powell Road 21788 USA Funeral 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 No White Specify. þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Plant Operator Water Plant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Luther Gladhill Elizabeth Snoots 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ray Gladhill/Brother 41 Tecota Street, Thurmont, MD 21788 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Resthaven Mem. Gard 4/25/2007 Frederick, MD 22. Name and Address of Facility Stauffer Funeral Home, PA 21. Signature of Funeral Service 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1 Cover the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheck, or heart failure. List only one cause on each line. Immediate Cause (Final IAM CHEATIC METASTATIC disease or condition resulting in death) Due to (or as a consequence of): EURAL EFFUSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner FIBRILLATION ATRIAL Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No. 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DIABE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 ER/Outpatient 3 DOA ို 1 Inpatient 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation (Month, Day Year) 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3∏ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 47951 4-23-07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FILEDERICK MD TOLL HOUSE Ave 1BTE KAZHI, MO 814

State Registrar

31. Date filed (Month, Day, Year)

APR 2 4 2007

within 24 h. To the Fur

32. Resstrar's Signature

		•	1 - For CCHD State RegistrarAMEND #26 PER	PHYS 4/	24/07			e of D			intai i iy	Reg. No	20	07	468
	Physicia	an	1. Decedent's Name (First, Middle, Last)								2. Date of De Month	Da	ıy	Year	3. Time of Death
1	/Medic		John Paul Grant				41: 01:	T1.			April		200	7 of Death	4:20 P M
	Examin	er	4a. Facility Name (If not institution, give street 39002 Hollybank Driv	,				Town, or Lo chani						Mary'	c
	Francis I		5. Social Security Number 6. Sex		(In yrs. last l	birthday)	If Under	1 Year	If Under 24		3. Date of Bir	th	T	9. Birthpl	lace (State or Foreign
ı	Funeral Director		211-30-5138 1 ¹ 2 M	2□ F	67	Yrs.	Months	Days	Hours	Min.	(Month, Da une 15	0, Year	939	Penns	ylvania
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Lo	cation							10	0d. Inside City Limits
	Maryl. f sho	Ď	Maryland St. Mary's		N	1echa	anics	/illa							1 ☐ Yes 2 X ☐ No
	r 28a	irec	10e. Street and Number	l	!!	icciic	10f. Zip					10g. Ci	tizen of \	What Coun	try?
	th with 23a oust be	Funeral Director	39002 Hollybank Dri	ve					659	_			US		
	tems tems	nue	Tr. Marital Otalas	Was Decedent E Armed Forces?		13. \	Nas Deced f Yes, spec	lent of Hisp cify Cuban,	anic Origi Mexican,	n? (Speci Puerto R	ify Yes or No ican, etc.))-		e - America ck, White, e	
336	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene, item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ⊠ Yes 2 □ N If Yes, Give Year or Dates:	lo		1□Yes a	2 🔀 No	Specify:				Specify	v: Wh	ite
21215-0036	72 ho 'natur dical 6	Completed	15. Decedent's Education (Specify only highest grade co		16	a. Deced	lent's Usua kind of wo	al Occupati rk done dui se retired)	on ring most o	of working	9	16b. k	Kind of B	usiness/Ind	lustry
121	filed within Hygiene. other than '	Jdwc	Elementary/Secondary (0-12)	College (1-4or 5-	+)			se retirea) perat					We	1ding	I
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Maryland	2 should be f and Mental I Is marked of au⊓atic eve	To B	John James Grant						He	elen	Kocis				
ary	shou and N smai		19a. Informant's Name/Relationship (Type.	Print)	1:	9b. Mailin	g Address	(Street an	d Number	or Rural	Route Numb	er, City	or Town,	State, Zip	Code)
	.1 and 2 Health a tem 27 is		Marie Grant - Wife						k Dri						20659
ore	to the transition of the trans		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ Remo	oval from State	20b. Place ceme	of Dispo tery, crer	sition (Nan natory or o	ne of htherplace)		Da	te	20c. L	ocation -	City or To	wn, State
Baltimore,	t. Pag tment tant: ijury		4 □ Donation 5 □ Other (Specify)		St. N									, MD	D 1
Ba	permit. Pages 1 Department of H Important: If ite any injury or ot once.		21. Signature of Funeral Service Licensee	M03	1391	1		d Address Funer			Waldor				n Road
			23a. Part1. Enter the disease, or complicati shock, or heart failure. List only one c	ons that caused ause on each lin	the death. D	o not ent	er the mod	le of dying,	such as ca	ardiac or	respiratory a	rrest,			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Chris	mic	Of	BSTR	UCTI	VE	LUN	1G A	SEA	ASE	_	Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as	a consequence	e of):	_								
		e.	Sequentially list conditions, if any, leading to immediate	Due to (or as			•				-				
	uted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events C.	CVA											
o,	e exec an an irial-tr		resulting in death) Last	Due to (or as	a consequenc	e of):									
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	se as	/Me	IF FEMALE: 23c	If yes, outcome	of pregnancy								004 Da	to of delive	
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P.O.	that the dened by the statement	hysi	9 Unknown	9□Unknown											
	res tha igned l	by P	Part II. Other significant conditions contrib	uting to death bu	ut not resulting	g in the u	nderlying c	ause given	in Part I.						ne cause of death?
ord	w require been sign	ted									10	Yes 2	2 No	3∐ Prob	ably 4 Unknown
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a	i cian : Th certificate ector, pag		25. Was case referred to medical						20 Pl-	- f D #-	1□ Yes	2 1 0 N		1 ☐ Yes	2 □ No
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ion	Attending F r death. ector: After by the funer	atio	1 Natural 5 Pending 2 Accident investigation	(WOIIII, Da)	/ rear)	ilijury	М		es 2∐N	lo					
Division	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of inju- building, etc		farm, str	eet, factor	y, office		28	Bf. Location (City or To			ber or Rura	il Route Number,
	spital ours a neral [29a. Certifier 1 Certifying Physici	an: To the best	of my knowled	ige, deat	h occurred	at the time	e, date and	l place, ai	nd due to the	cause(s) and m	anner as si	tated.
	To the Hospital within 24 hours a To the Funeral completely filled	Medical	(Check only 2 Medical Examiner one)		examination										
	To the Complete Compl	Ž	29b. Signature and title of certifler	11/11	0	h		c. License r				29d. D.	ate signe	ed (Month,	Day, Year)
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(RIEL		30. Name and address of person who comp					Loon	2 md + 0	n	MD 204	550			
ba	Sta	to.	Rakhi Krishnan, 268 31. Date filed (Month, Day, Year)	32. Puljistra	ar's Signature	յսն հ	wau,	Leon	aruto	, 11 W	עויו עטיי	100			
	Registi		31. Date filed (Month, Day, Year) APR 2 4 20	07 Here	ar's Signature	× 6	back	1							

Registrar

Spark

		1 - For State Ragistrar	State o	of Marylar				ealth a Death	and M	1ental Hyg	giene Reg. No.	007	14582
Physici	22	Decedent's Name (First, Middle								2. Date of Dea Month	ath Day	Year	3. Time of Death
Physici /Media		Ruth Alice Ho								April_	19,	2007	1652 M
Examir	ner	4a. Facility Name (If not institution Prince George						Location o	of Death			County of Death	
Alexander (Contraction of Contraction ***	5. Social Security Number	6. Sex	7. Age (In yrs.			heve 1 r 1 Year	If Under	24 Hrs.	8. Date of Birt		rince Ge	place (State or Foreign	
Funeral Director	s i	577-58-6924	1 □ M 2 1 F	63	Yrs.	Months		Hours	Min.	(Month, Da)	v. Year)	Cot	intry)
D		Usual Residence of Decedent											
arylar	_	D.C. 10b. County		10c. Ci	ty, Town or Lo	ocation Wash:	inata	n					10d. Inside City Limits 1 XYes 2 No
7-88-1	Director										10- 011		
with t	ក់	10e. Street and Number 5066 Benning R	ad C E	#3			Code :: 0019					sen of What Cou	antry ?
leath ne 23	Funeral	11. Marital Status	12. Was Dec	edent Ever in U	I.S. 13.	1		spanic Ori	gin? (Sp	ecify Yes or No- Rican, etc.)		4. Race - Amer	ican Indian,
after after a		1 X Never Married 2 ☐ Marr	Amed Formed I □ Yes	2 (XNo					i, Puerto	Rican, etc.)		Black, White	
72 hours after death with the Maryland 72 hours etterna 23a or 28a-1 ehow dical Examinational be notified at	d by	3 Widowed 4 Divorced	If Yes, G Year or I	Dates:		1 🗆 Yes	2 (A) NO	Specify:				Specify: Bla	CK
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withir ene. then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	me.	Cook	ise retired	,			And	rews All	rforce Base
Hygi other	a)	17. Father's Name (First, Middle,	Last)			COUR		18. Mothe	er's Nam	e (First, Middle,	Maiden	Sumame)	
Ald be Menta	To B	Elmer Holmes						Hat	tie	Forste	r		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itema 23a or 28a-1 show appringing or other traumatic event, the Modical Examination at an ance.		19a. Informant's Name/Relations			19b. Maili 706 F	ng Addres	s (Street a	and Numbe	or Run	al Route Numbe V e	er, City or	Town, State, Zi	ip Code)
and and a n 27		Andrew Victor M	ccluney/s		Fort	Wash	ingto		ary1.	and, 20	744		
T of H		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	3 Removal from	State	Place of Dispo cemetery, crea	matory or	other plac			Date		cation - City or T	
rmit. Pages partment of portant: if it portant: if it y injury or o		4 Donation 5 Other (S		Re	surrec			1				ton, Ma	ryland ne, Inc.
Department of the post of the		21. Signature of Funeral Service	1 R	an ou a	1				-				.C. 20010
Physician /Medical Examiner	1	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	a	caused the deal	Card	,	•		r , 1	or respiratory ar	rest,		Approximate Interval Between Onset and Death
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The law requires that the death certific the law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 Live	tcome of pregn birth 2 ☐ Feta nant at time of d	al déath 3[⊒Ectopic p ⊒ Other (s					2	3d. Date of delik Month	very Day Year
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Physic this ce	To	1 ☐ Yes 2 ☑ No			R/Outpatie	nt 3 D	OA Othe	9r: 4 □ Nu	irsing Ho	me 5 Resid	dence 6	Other (Spec	ify)
ing P	 	27. Manner of Death 1 ☑ Natural 5 ☐ Pendir	28a. Date (Mor	of Injury oth, Day Year)	28b. Time o Injury		28c. Injury Work			28d. Describe h	ow injury	occurred	
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	ertification:	2 Accident investi 3 Suicide 6 Could 4 Homicide determ	not be 28e. Ptac	e of Injury - At h ing, etc. (Speci	ome, farm, st	M reet, facto		Yes 2 🗆	No	28f. Location (S City or Tox			ral Route Number,
the Hospitu in 24 hours the Funera pletely fille	ledical C	(Check only 2 Madical one)		e best of my kno easis of examina iner stated.	owtedge, deat ation and/or in	th occurred ivestigation	at the time n, in my op	ne, date an pinion, dea	d place, th occur	and due to the red at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
To I To I	Σ	29b. Signature and title of certific	//			29	c. License		,			signed (Month	
(0)		1 (/)	110					957				-22-0	7
- (H)		30. Name and address of person	who completed cau	se of death (Iter	m 23a) (Type,	Print)	1	heuro	4/11	MD	120	785	
Sta	ate	31. DAPR (24 2007)	32.1	Registrar's Signa	ature	V 1 / V (.012	ny		20	100	
Regist		AFR 2 4 200/	An a	A 1	4 11			1					

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 26, 200, 4c. County of Death Apri 3:00 AM Gerald Elby HOAK /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington County Hospital Washington Hagerstown If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthdav) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 M 2 □ F Yrs. 73 Aug. 10 1933 Virginia Director 226-36-6586 Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hyglene. s marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Washington Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 17821 Red Oak Drive 21740 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: Korean 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 XYes 2 □ No Specify: Specify: Completed by 3 X Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) a. Decedents usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Assistant to Director of Legal Affairs Elementary/Secondary (0-12) College (1-4or 5+) Power Company 12 4 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked othray any Injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) Be ပ္ John Hoak Hazel Lillard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) James Hoak - Son 406 Brookline Avenue, Hagerstown, Md. 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery 4/30/07 Hagerstown, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Minnich Funeral Home L. Vestal fred 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Interdnel day Ischemic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Lines of unerlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed the burial-tran Due to (or as a consequence of) physician Physician/Medical asi attending IF FEMALE use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Day ō in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed? After this certificate funeral director, pag 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 ☑ No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident hours after death. within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 24

Q5H-5+1

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Records,

Division or Vital

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Michael

McCornecis 11/10 32. Regarar's Signature Marken Strain

30. Name and address of person who/completed cause of death (Item 23a) (Type, Print)

medical

29c. License number

041667

Compres Svita 130

29d. Date signed (Month, Day, Year)

26.0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U U Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Year Jerry Lee Hamm 07:15 MPM 22 April 2007 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6 Iverness Drive North East 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min 1XM 2□ F Yrs. Director 216-44-2479 61 November 2,1945 Maryland Usuel Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f ehow I Health and Mental Hygiene. Item 27 Is marked other then "nature!", or Itema 23a or 28e1 shov other traumatic event, the Musical Examinant Le multified at 1 Yes XXNo Director Maryland Ceci1 North East 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 Iverness Drive Funeral United States death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2X Married 1 ☐ Yes 2 🔀 No Specify. Completed by Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Elementary/Secondary (0-12) College (1-4or 5+) 8 Printer Newspaper Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be fill and Mental H Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 271e marked eny Injury or other traumatic everages. Burley Hamm 2 Florance Lofthouse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen G. Hamm 20b. Place of Disposition (Name of cemetery, crematory or other place)

North East, Maryland 21901
20c. Location - City or Town, State / Wife Baltimore, 20a. Method of Disposition %Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) North East Methodist 26, 2007 North East, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland21901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner or Attending Physicien: The law requires that the death certificate be executed ettending physicien and for use as the burial-translt that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete 2 40 1 Yes 2 | No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 2 1 Yes 2 Ho 2 ER/Outpatient 3 DOA After the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: s after dea... 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, me and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

21215-0036

Division of Vital Records. P.O. Box 68760.

32. R sistrar's Signature

DIMONSON

2007

APR 23

31. Date filed (Month, Day, Year)

			For State Registrar	State of Ma	ryland / I		rtment of H tificate of I		ınd Mei		giene) Reg. No.	007	4685
			Decedent's Name (First, Middle, L.)	ast)					2.	Date of Dea	ath		3. Time of Death
	Physici		Michael	T. HYMA	· C ·				Д	Month pril:	20, 2	OO7	4:00 a _M
	/Medic Examin	i	4a. Facility Name (If not institution, g	ive street and number)			4b. City, Town, or	Location of				ounty of Death	
		5	1803 Kipling D	rive			Salisbu	ırv			Wi	comico	
	Funeral			Sex 7. Age	(In yrs. last bi	irthday)	If Under 1 Year Months Days		24 Hrs. 8. Min.	Date of Birt (Month, Da			nplace (State or Foreign untry)
	Director		067-22-6693 Usual Residence of Decedent	1X M 2 □ F 7	9	Yrs.	World S Days	Hours		7/29/1			York
	P .		Usual Residence of Decedent 10a, State 10b, County		10c. City, Tov	vn or Loc	eation			.,,			10d. Inside City Limits
	ehov	Ľ.											1 St Yes 2 □ No
	28a-f	Director	Maryland Wicom	1CO	Salis	bury	1				10a Citiza	en of What Co	intar?
	be filed within 72 hours after deeth with the Maryland tal Hyglene. Id other than "natural", or items 23s or 28s-f show event, the Medical Examinar must be multified at		10e. Street and Number 1803 Kipling	Drive			10f. Zip Code 21801				US		and y :
	ns 23	Funeral	11. Marital Status	12. Was Decedent B	ver in U.S.	13 W			in? (Specif	v Yes or No		. Race - Ame	ican Indian,
	iter d	5	1 □ Never Married 2 ☑ Married	Armed Forces?		If	Vas Decedent of H Yes, specify Cuba	an, Mexican,	, Puerto Ric	an, etc.)		Black, White	
3	urs a	þ	3 Widowed 4 Divorced	1 ☑ Yes 2 □ N If Yes, Give Year or Dates:		1	☐ Yes 2又 No	Specify:			S	Specify: W	hite
9500-612	2 ho	Completed	15. Decedent's (Specify only highest of	Education	16a	a. Decede	ent's Usual Occup	ation	of working		16b. Kind	d of Business/l	ndustry
7	within 72 ene. then "na he Medic	ple	Efementary/Secondary (0-12)	Colfege (1-4or 5	+)	life. D	O NOT use retired	d)	or working				
7	or th	Son	12			Appr	aiser					raising	<u> </u>
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yland	should be ind Mental imarked o umatic eve	ပ	thomas Francis							nica V			
Mar	and and and	u a	19a. Informant's Name/Relationship	* **		,	Address (Street				-		ip Code)
	s 1 end 2 of Heelth item 27 l		Mary Jane Hynes/	wile			Kipling	Dr.,	Date				Faura Chata
0	ges 1 t of H if ite or ot		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3	☐Removal from State	cemete	ery, crem	sition (Name of latory or other plac					ation - City or	
	Pa tmen tant:		4 □Donation 5 □Other (80e)	-	Sali	-	y Cremato					sbury,	
Baltimore,	permit. Pages 1 Depertment of H Important: If its eny injury or ot 2008.		21. Somure of Funeral Selvin Li		-	22 5	MT18Way Ol Snow	funer Hill	al Ho	me Pro Salisk	ofess oury,	ional A MD 218	Association 304
			27a. Part1. Enter the disease, or co	mplicar ns tha used	the death. Do	not ente	er the mode of dyin	g, such as	cardiac or re	espiratory a	rrest,		Approximate Interval Between
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	/Medical		resulting in death)	a Due to (or as a	a consequence	of):	COM	271					
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	ם א	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a consequence	of):			0				
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×	ding I	/Me	IF FEMALE:	23c. If yes, outcome	of oregnancy						0.0	ad Data of dali	· · · · · · · · · · · · · · · · · · ·
XOC	death certifi e attending I id for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetaf deat		Ectopic pregnancy Other (specify)	/			23	3d. Date of deli Month	Day Year
o.	0 0	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	une or death	30	Other (specify)						
J.	law requires that the as been signed by th 2 should be detache	H.	Part II. Other significent conditions	contributing to death bu	ut not resulting	in the un	derlying cause giv	en in Part I.		23e. Did t	obacco us	e contribute to	the cause of death?
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Ö	w requir been si should	lete						_		24a. Was	an	24b. Were au	topsy findings available
ě	0 - 0	Completed								autor perto	osy ormed?	prior to death?	completion of cause of
	ician: Th certificete rector, pag	e Co	25. Was case referred to medical						-/ D/- //	1 Yes		1 □ Yes	2 □ No
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0	th. : After s tuner	ig ig	1 □ Natural 5 □ Pending 2 □ Accident investigat	(Month, Day	Year)	Injury		k? Yes 2.∐1	No				
Division of	r Attending ter death. irector: After by the fune	Hca	3 ☐ Suicide 6 ☐ Could not	286. Prace of inju	ıry - At home, f	arm, stre	eet, factory, office		28f			Number or Ru	iral Route Number,
ā	F 6 F	Certification:	4 ☐ Homicide	building, etc	:. (Ѕресіту)					City or To	wn, State)		
	To the Hospital or within 24 hours after to the Funeral Dir. completely filled in	edical (29a. Certifier 1 Certifying (Check only 2 Medical Ex	Physicien: To the best of aminer: On the basis of	of my knowledg	je, death	occurred at the tir	me, date and	d place, and	d due to the	cause(s) a	and manner as	stated.
	the H lin 24 the F pplete	ed	one)	and manner sta	ted.				ui occumed	at the time,			
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	000		30. Name and address of person wh	o completed cause of de	eath (Item 23a)	(Type, f	Print) Ty	151	men	T ff	, <u>,</u> ,	010	6.4
	T		31 Date file Worth Day Year	am 540	1 E	NV	105 1.DG	uisl	DUNY	1	(1)	218	04
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Cleopatra **Imes** 11:55 A. April 19. 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Clinton Southern Maryland Hospital Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Min. | July 29, 5. Social Security Number 7. Age (In yrs. last birthday). 9. Birthplace (State or Foreign **Funeral** 1 M 2 XX Yrs. Maryland Director 577-44-8910 Usual Residence of Decedent death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "netural", or items 23a or 28a-f show any Injury or other treumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Capital Heights 1XYes 2 No Maryland Prince George's Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20743 1002 Nyanga Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2XXNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Black Specify: \$ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Woodward & Lothrop 12th grade Seamstress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ethel C. Jackson Raymond Mason ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1002 Nyanga Avenue Capital Heights, Maryland 20743 Mrs. Ethel Cannon-Carvin (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mount Olivet Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State April 28, 2007 Washington, D.C. 4 Donation 5 Dother (Specify) 21. Sign tun of Funeral Service Licenses 22. Name and Address of Facility Rollins Funeral Home, Inc. 4339 Hunt Place, N.E. Washington, D.C. se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part1. Enter the disease, shock, or heart failure. L Approximate Interval Between Borchornemania Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate caus. Enter the Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) certificate has been signed by the irrector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed: 2 3 No or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To To the Hospital or Attending Phys within 24 hours after death.

To the Funerel Director: After this 28a. Date of Injury (Month, Day Year) 27. Manne of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 19 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical ner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 2 ☐ Medical E 29c. License number 29b. Signature and title of certifi-29d. Date signed (Month, Day, Year) 0055120

State Registrar

1328 Suntum 31. Date filed (Month, Day, Year) 32. Registrar's Signature APR 2 4 2007

(in)

irhome

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

avenu SE Surte 310

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Deeth 3. Time of Death Month 2007 Johnsor dianon 4e Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Spring If Under 24 Hrs. Montgomen DI ta If Under 1 Year 8. Date of Birth (Month, Day, Year) 2-12-1916 5. Social Security Number 9. Birthplace (State or Foreign Country) Age (In yrs. last birthday) Months Days Hours 1□ M 220 F 578226088 Usual Residence of Decedent Yrs. 10a. Stete 10c. City, Town or Location 10d. Inside City Limits Silver 1 Yes 2 □ No Spring 10f. Zip Code Montgomer 10g. Citizen of What Country? 10e. Street and Number 0910 1316 ane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 20 No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 22 No Specify: Black 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Public Elementary/Secondary (0-12) College (1-4or 5+) incic 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Bolder 101a Willie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomasina Cootley Cousin 1909 Callaway St. Temple Hills MD 20748 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State n Memorial 4/23/07 Switland M 22. Name and Address of Facility Greene Funeral Home 4 Donation 5 Dother (Specify) incoln Memorial 21. Signature of Funeral Service Licensee nelson (314 Franklin Street Alexandria VA-22314 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metabolic Encephalopathi Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? Multiple Decubitus 212010 1 ☐ Yes 2 ☐ No Demetia 1 Ves 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Hospital: 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Deeth 1 Maturet 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner or Attending Physician: The law requires that the death certificate be axecuted

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be

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Funeral

Director

Pegas 1 end 2 should be filled within 72 hours after death with the Marylend nant of Heatth end Mentel Hygiene. Int: If Item 27 is marked other than "natural; or items 23e or 28e-f show

21215-0020

Saltimore, Maryland

?? is marked other than "natural", or items 23a or 28a-f shor traumetic event, the Medical Examiner must be northed at

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: within 24 hours eftar death.

To the Funeral Director: After this certifice complataly filled in by the funeral director, it 10 State Registrar

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

3 Suicide

29a. Certifier

4 Homicide

Multiple Venous Thrombosis

6 Could not be determined

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Location (Street and Number or Rural Route Number, City or Town, State)

29c. License number 47867

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29d. Date signed (Month, Day, Year)

30. Neme end address of perause of death (Item 23e) (Type, Print) 1500 Forest Glen Road Silver Spring MD20902

31. Date filed (Morth, Day, Year)

29b. Signature end title of certifier

APR 2 4 2007

32. Registrer's Signature

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend #8 per FH 04-25-2007 Cardificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 13 Kelvin Cordell Jones April 2007 8:12 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Holy Cross Hospital Silver Spring Montgomery 0 (34 of Birth y 1962 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Days XXM 2□ F 224-13-3939 DC Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. ther than "naturel", or Iteme 23a or 28e-1 show 10b. County 10c. City, Town or Location ?7 is marked other than "naturel", or iteme 23a or 28e-f ehow treumatic event, the Medical Examin or must be incitied at 10d. Inside City Limits ¶ Yes 2 No Director Silver Spring MDMontgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11225 Columbia Pike 20901 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Paralegal Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Unknown Sonja Elizabeth Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shelby Jones - Sister 1629 Taylor Ave., Fort Washington, MD 20744 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages nent of h 1X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Mt.Olive Cemetery 4/25/2007 Lincoln, Virginia 22. Name and Address of Facility Loudoun Funeral Chapels 21. Signature of Funeral Service Licenses 158Catoctin Cr., SE, Leesburg, VA 20175 23a. Part 1. Enter the prease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he introduce. List only one cluse on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine signed by the attending physicien and d be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No page 2 autopsy performed 1 Yes 2 No or Attending Physician: ours after death. heral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 🔀 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification; 5 Pending 1 Natural investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) BD9110519 April 19, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maria D'Arbella, Holy Cross Hospital, 1500 Forest Glen Rd., Silver Spring, MD 20910-1483 31. Date filed (Month, Day, Year) APR 2 4 2007 State Registrar

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Ma		ment of Health and ficate of Death		Some of the f	14689
	Physici /Medic		1. Decedent's Name (First, Middle, La	it)).	Jack	KSON)	2. Date of Death	P O 7	3. Time of Death
	Examin Funeral Director		215-16-12-16	Hospita	a (In yrs. last birthday)	b. City, Town, or Location of Dea f Under 1 Year Iff Under 24 Hr Ionths Days Hours Mir	s. 8. Date of Birth	One S	e + plece (State or Foreign intry) Md
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23e or 28e-1 show any injury or other traumatic event, the Medical Execution in must be notified at Once.	To Be Completed by Funeral Director	Usuaf Residence of Decedent 10a. State 10b. County 10e. Street and Number 28	Coffege (1-4or:	Ever in U.S. 13. Was If Ye If	10f. Zip Code 2 18 38 s Decedent of Hispanic Origin? (es., specify Cuban, Mexican, Puel Yes 2 10) No Specify: It's Usual Occupation of of work done during most of work not use retired) 18. Mother's National Code of the North State of the	Specify Yes or No- into Rican, etc.) 16b. Orking First, Middle, Malde Rural Route Number, City	14. Race - Amer Bleck, White Specify: Bl	ican Indian, etc. Cook ip Code)
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P.O. Box 68	es that the death certific gned by the attending p be detached for use as I	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant conditions of	4□Pregnant a 9□ Unknown	2 Fetaf death 3 Ect t time of death 5 Ot	topic pregnancy ther (specify) rtying cause given in Part I.	T		very Day Year the cause of death?
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۵	To the Hospital or within 24 hours after to the Funaral Director completely filled in I	edical Cer	29a. Certifier 1 Certifying Ph	vsician: To the best	of my knowledge, death oc	ccurred at the time, date and plac tigation, in my opinion, death occ	ea and due to the cause	(s) and manner as	stated. to the cause(s)
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	Sta Pegistr		30. Name and address of person who Signature 1 of the Signature 1 of t	KARUM	death (Item 23a) (Type, Prin PONATHA rar's Signature	N 201 HA	ALL HIG	HWAY, C	RISFIELDMI 21817

DHMH 17 Rev 1/2001

			For Amend Stete Registrar WCH	Item #1 D/SH 4/3	State of Ma 30/07 per I		Departmer Certificat				giene Reg. No.	007	14690
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,	Examin		4a. Facility Name (If no	ot institution, give	street and number)		4b. City		ocation of Death		4c. 0	County of Death	
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	permit. Pag Department Important: t any injury o		21. Signature of Fune	raf Service Licen	S00		22. Name a	nd Address				Funera	
n	40 E # 9		- Jelle	Lee.	_	101414						, Maryl	and 21783
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į, i	Physician		Immediate Cause (Fir disease or condition resulting in death)	naf	a		Se	P315					03/5
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	To the Hospital or within 24 hours effection 25 to the Funeral Discompletely tilled in	Medical	29a. Certifier 1 (Check only 2 one)	☐YCertifying Ph ☐ Medical Exen	ysician: To the best o niner: On the basis of and manner stat	examination an	e, death occurred d/or investigation	d at the time n, in my opi	e, date and place inion, death occu	e, and due to the urred at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
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5 F	4-10+1		30. Name and address	Λ .	completed cause of de	eath (Item 23a)	(Type, Print)	ite 30	57 ves	minster	M	02115)
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ORIGINAL

Registrar

State

NMHS Frostburg Nursing & Rehab

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month; Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year 150 P.M **Physician** Betty Jane LYNCH /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington Hagerstown Washington County Hospital Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral** Months Davs Hours 1 □ M 2 🗓 F 83 26 1924 Pennsylvania Jan. Director 216-14-6843 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 No Director Hagerstown Maryland Washington 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 21740 11509 Green Valley Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify. Specify. Completed by 3 ₩ Widowed 4 Divorced White 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Physician Receptionist 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruth Riggleman Russell H. Sanderson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11509 Green Valley Drive, Hagerstown, Md. 21740 Betty Jane Lynch - Self 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 → Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/30/07 Hagerstown, Maryland Rest Haven Cemetery 22. Name and Address of Facility Minnich Funeral Home 21. Signature of Funeral Service Licensee L. Vesta 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or a a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23d. Date of delivery 23c, If yes, outcome pf pregnancy 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9∏Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No 2□ No 1 TYes 1∏ Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 1 ☐ Yes 2□ Ño 3□ DOA မ 28a. Date of Injury 28d. Describe how injury occurred 28h. Time of 28c. Injury at Work? 27. Manner of Death Certification: (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 □ Yes 2 □ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 □Could not be 3 ☐ Sulcide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

that the death certificate be executed Box 68760, P.O. Records, Division or Vital To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After

physician and s the burial-tran

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After this funeral

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filled in by

Medical

29a, Certifier

(Check only one)

29b. Signature ar

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

COH-C

State Registrar

DHMH 17 Rev 1/2001

Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

License number

29d. Date signed (Month, Day, Year)

07-02981 Edward R. Lynch, 2nd

Med

Please Type or Print in State of Marylar

Black Indelible Ink. Ensure All Copies Are L	egible.		
nd / Department of Health and Mental Hygiene		2007	11,593
Certificate of Death	Rea No	has been been a	1 1000

		- For State		Certifi	cate of I	Death		Reg.	No.	10 7 10 0			
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Examin		4a. Facility Name (if not institution, give s			41	. City, Town, or Lo	ocation of Death						
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5-0036 led within 7 Hygiene. I other that	Completed	12 17. Father's Name (First, Middle, Last)					18.Mother's Name	e (First, Middle, M	laiden Surname)				
21215-0036 uld be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23a or 28a-f she event, the Medical Examiner must be notified at once event, the Medical Examiner	Be	EDWARD	R.	LYI	NCH		DORIS		ANNE	BUNTING State Zin Code)			
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ore, M es 1 and 2 of Health If item 2 ther traus		1 Burial 2 X Cremation 3	Removal from S	State cre	ematory or ot	her place)	Į.	124.107	DEIMA	D DELAWARE			
Page ment tant: or ot		4 Donation 5 Other Specify:	Other Specify: CREMATORY OF DELMARVA 4/24/07 DELMAR, DELAWARE 22. Name and Address of Facility										
Baltimore, permit. Pages 1 a Department of He Important: If it in injury or other t		21. Signature of Funeral Service Licent	HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975										
Physician	H	23a. Part I. Epper the disease, or comp	lications that cause	ed the death. I	o not enter	the mode of dying,	, such as cardiac	or respiratory arr	est, shock, or he	art Approximate Interval Between Onset and			
'edical		failure. List only one cause on ea	ch line. Multiple Injurie							Death			
aminer		minicolate eases (Due to (or as a cor										
	_	Sequentially list conditions, b.	Due to (or as a cor	sequence of)	:								
	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated											
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sion ttendi death.		Natural 5 Pending 2 Accident Investiga			ome farm si	reet, factory, office		28f. Location	(Street and Num	nber or Rural Route Number, City			
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Division To the Hospital or Attend within 24 hours after death, with the Funeral Director:				-f lunguilod	an donth on	curred at the time,	date and place,	and due to the ca	use(s) and mann	ner as stated.			
the H hin 24 the Fu	plete	(Check only 1 Certifying Physical Examin 29b. Signature and title of certifier	er:On the basis of and manner sta	examination a	and/or investi	gation, in my opini	ion, death occurre	ed at the time, da	te and place, and	3 440 10 1110 11111111			
To To To	loo	29b. Signature and title of certifier	and mantier sta	ieu.		29c. Lice	ense number		1	gned (Month, Day, Year)			
		1 audl	- HB	UU	ll	0.0	C.M.E.		April 20,	2007			
2 54		30. Name and address of person wh	o completed cause	of death (Iter	n 23a)		MD 04	201					
DIM		Carol Allan, MD Assis	tant Medical E	xaminer	111 Pen	n Street, Balti	imore, MD 21	201					
	Si-	te 31. Date filed (Month, Day, Year)	2007	listrar's Signat	ture	Carte 1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend. item. 16b per th 9867 5-7-07 vt. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** HARVEY W. MITCHELL Apri1 26 2007 7:00 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1821 Glenville Road Havre de Grace Harford If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1**X** M 2□ F Yrs Director 218-26-2019 77 1/5/1930 Virginia Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Item 27 is marked other then "natural", or Items 23a or 28a-f show other treumatic event, the Medical Examinar must be notified at MD Harford Havre de Grace 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1821 Glenville Road 21078 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 X Yes 2 No If Yes, Give Year or Dates: 1947-50 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No White ģ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Civil Service Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: If Item 27 is marked other the eny injury or other treumatic event, than once. Material Sorter 11 Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Arthur N. Mitchell Carrie Bell Holmes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Mitchell/Wife 1821 Glenville Road, Havre de Grace, MD 21078 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evans Eagle Crematory 4/30/2007 Leola, PA 21. Signature of Fungral Service Licensee 22. Name and Address of Facility Harkins Funeral Home, Inc., Delta, PA 17314 ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. Approximate Interval Between Onset and Death art 1. The the dise se, or shock, or heart failure. List mediate Cause (Final **Physician** ling Caryudha disease or condition resulting in death) /Medical Due to (or as a consequent of): Examiner Sequentially list conditions, Due to (or as a nonsequence of) Examiner any, leading to immediate cause. Enter Underlying Cause (Disease or injury ed by the ettending physicien and detached for use as the burlal-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 ☐ Probably 4 ☐ Unknown Yes 2□No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy this certificate 1 Yes 2)X No or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٥ 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident in by the Director 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury · At home, larm, street, lactory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours efter To the Funeral Dire the Hospital 1 Certifying Physician: To the bast of my knowledge death commed at the time, date and place, and due to the date of the date of the date of the date and place, and due to the cause(s) and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal (Check only one) Medi 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifiq 29c. License number april 27 2007

State Registrar

June

31. Date filed (Month, Day, Year)

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ath (Item 23a) (Type, Print)

West

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene-

1 - State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death April 1 **Physician** 23, 2007 Edith Eckhart MacMannis 7:00 P. M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Allegany 632 National Highway LaVale If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days 1 □ M 2 🔏 F Months 212-38-7339 97 Yrs. Director Mar. 16,1910 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Allegany LaVale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 632 National Highway 21502 U.S.A. "naturel", or items 23a death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ᠿ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc permit. Pages 1 and 2 should be filed within 72 hours after c Department of Heelth and Mental Hygiene. Important: if item 27 is marked other then "nature!", or iter propriatory or other traumatic event, it a Medical Enais. In one. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2x No Specify: Specify. þ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Rachel Pengelly John Thomas Eckhart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edith Elvee Niece 16262 Harwood Dr., SW, Frostburg, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Eckhart Cemetery May 3, 2007 Eckhart, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Rafer Funeral Service, PA 1302 National Hwy., LaVale, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Made /Medical (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed burial-transit enoso that initiated events ettending physicien and resulting in death) Last to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 1 ☐ Yes 2 No detached 9 Unknown Partificather significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ 100 2 NO 1 Yes Hospital or Attending Physician: 4 hours after death. Funeral Director: After this certifica funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one, Other: 4 Nursing Home Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 ☐ Yes 2 No Certification: To 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 T Homicide within 24 hours a 29a. Certifier 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number April 30, 2007 MDD54411 30. New e and address of person who completed cause of death (Item 23a) (Type, Pint) Beverly Calkins, MD, 500 Memorial Ave., Cumberland, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2007

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month **Physician** ELIZABETH MAXE JUCILLE 8:04PM /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 12000 Morning Dove Lane SE Cumberland Allegany If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Jan 26, Birthplace (State or Foreign Country) **Funeral** Months 1□M 21 F 1920 Director 220-10-4100 87 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location •how 10d. Inside City Limits f Health and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23s or 28s-1 shov other traumatic event, the Madical Examinar must be notified at MD Allegany Cumberland **Funeral Director** 1 Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 12000 Morning Dove Lane SE 21502 USA death 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed withIn 72 hours after ☐Yes 2☐No fYes, Give X 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: þ Specify: Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Joseph Siefers Edna Herpich Siefers ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12000 Morning Dove Lane SE Cumberland MD 21 19a. Informant's Name/Relationship (Type, Print) Barbara Lyons daughter MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages of Department of Huportant: If ite eny injury or of once. 1 Nourial 2 Cremation 3 Removal from State Sunset Memorial Park 5/5/2007 Cumberland MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fun ral Service Licensee 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part. Enver the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SLADOEN L'EMPHOMA ONE TEAM /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (ur as a consequence of): Examine The law requires that the death certificate be executed ng physicien and as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical attending for use as IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Dav 4☐ Pregnant at time of death signed by the a d be detached for 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 IX No s certificete hes birector, page 2 s 24a. Was an autopsy performed? Yes 2 No 1 Yes Hospital or Attending Physician: ector: After this certific by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide filled within 24 hours e To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai completely (Check only one) ŝ 29b. Signature and title of confife 29c. License number 29d. Date signed (Month, Day, Year) D33417 (MAREUM) 2, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JAMES R. MOTO, M.D. LAVACE, MARYLAND 21502 1068 NATIONAL HILGHTWAY 31. Date filed (Month, Day, Year) 32. Agistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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State of Maryland / Department of Health and Mental Hygiene

William Jef	frey M	1	- For State	State of	Marylan		artment of rtificate of		nd Menta	l Hygi		eg. No.	20	107 145
Phy	vsicia	ın/	Registrar 1. Decedent's Name (First, Mic	ldle,Last)							Date of Deat	h		3. Time of Death
Me'' 'al E			William Jef		itche:	L1				Á	nonth pril 18, 2	Day 007	Year	0547 hrs
*,			4a. Facility Name (if not institu Prince George's Ho			oer)	4	b. City, Town, Cheverly	or Location of E	Death		1	unty of Dec	
F	neral		5. Social Security Number	6. Sex		. Age (In yrs. I	last hirthday)	If Under 1 Ye	ear If Under 2	4Hrs. 8	Date of Bir			. Birthplace (State or
Dire			578-78-6018	1 X M	1	49	Yrs.		ays Hours	Min	July 9		Fo	oreign Country) DC
		ŀ	Usual Residence of Decedent	1 1 2 3 1 1 1				<u> </u>			July .	,, 1	5,	
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and	items 23a or 28a-f show ust be notified at once.	٥	MD Prin	ce Geo	rges	D:	istrict							1 Yes 2 X No
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5-0036 led within 7 Hygiene.	Med th	ompleted	17. Father's Name (First, Midd	le Last\	1 yr.		Truc	k Drive	18.Mother's I	Name (Fi	st Middle I			Management
215- be filed	nt, the	ပ			h o 1 1						. Gibl		nume)	
212	mari	10	William Josep 19a. Informant's Name/Relation	nship (Type,	, Print)		19b. Mailing	Address (Str	eet and Numbe	er or Rura	Route Num	nber, City o	or Town, S	State, Zip Code)
A D She th and	n 27 is iumat		Vera A. Mitch	e11/Wi	fe									1D. 20747
s l an	If iten		20a. Method of Disposition 1 X Burial 2 Cremat	ion 3	Removal from		Place of Dispos crematory or oth		cemetery,	D	ate	20c. Loc	ation - Cit	ty or Town, State
imore, Pages 1 ar	ant:		4 Donation 5 Other	Specify:			armony M						dover	, Md.
Balti permit. Departm	Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Servi	ce Licensee	1.00	7			s fune					
Physi		\dashv	23a Part I. Enter the disease,	or complicat	tions that cau	ised the death	h. Do not enter t	217 9th he mode of dvir	St. N.	W. diac or re	Vashir	est, shock,	or heart	20011 Approximate Interval
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OX (for use	I	1 Yes 2 No 9	Jnknown d	Pregna Unknov	nt at time of d	leath 5 Ot	her (Specify)						
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<u>स्</u>	ertifica stor, p	a)	25. Was case referred to med	ical				26.Pl	ace of Death (C	heck only	one)			
of Vital Records, ig Physician: The law requir	After this certificate has been s funeral director, page 2 should	To B	examiner? 1 ✓ Yes 2 No	Hosp	pital: 1 In	patient 2 🗸	ER/Outpatient			Nursing F	ha	Residenc		Other:
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Division tal or Attendi	eral Director: filled in by the	iţi		ould not be	28e. Place	of Injury - At	home, farm, stre	et, factory, offic	e building, etc.					or Rural Route Number, City
spital	fille	Certifi	4 Homicide	etermined	1,		ad / Highway							ve, Landover, MD
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	· - 5	ž	29b. Signature and title of cer		^				ense number				_	(Month, Day, Year)
			(aunt	erke	ell			0.	C.M.E.			April 1	18, 200	7
CRI	6/		30. Name and address of per- Laron Locke MD.		•	of death (Ite Examiner	•	Street Ba	Itimore, MD	21201			-	
VI- (ate	31. Date filed (Month, Day, Ye			istrar's Signa			.amore, wib					

Registrar

07-03047

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Kristen Margaret Me	Ske 1- For State	State of Mary	land / Depar	rtment of tificate of	Health	and	Menta	al Hygie			20	107 145
	Registrar 1. Decedent's Name (First	t Middle Last)	Cert	ilicale of	Dealin				Date of Death			3. Time of Death
Physician/ Me Examiner	1. Decedents Hamo (1 mos	Kristen Ma	rgaret Me	eske				A	Jonth pril 21, 20	Day 007	Year	0252 hrs
)	4a. Facility Name (if not in			1	4b. City, To			Death			unty of Death	1
	University Hospit		1		Baltimo		y If Under	24Uro 19	Date of Birth		Vone	thplace (State or
Funeral	5. Social Security Number		7. Age (In yrs. la	st birthday)	If Under Months	1 Year Days	Hours	Min			Forei	gn Duntry)Wash DC
Director	220 21 6229		18	Yrs		<u>. </u>			Oct 4,	1988	3 0	Wasii DC
ану	Usual Residence of Dece 10a. State 10b. 0	County	10c. City,	Town or Locat	ion							10d. Inside City Limits
D Howa	MD I	Howard	Cla	arksvi]	lle							1 Yes 2 X No
the Maryland a or 28a-f sh lifted at onc	10e. Street and Number	lowara			10f. Zip C				10	_	of What Cou	
the M a or 2 tiffed	12161 Flow:	ing Water Tı	rail		210						ted St	
ms 23	11. Marital Status		Decedent Ever in U. I Forces?	S. 13. Wa	as Deceden es, specify	t of Hisp Cuban,	anic Origi Mexican,	n? (Specif Puerto Ric	fy Yes or No- an, etc.)	14.	. Race - Ame White, etc.	rican Indian, Black,
r death with or items 23 must be no	1 X Never Married 2	1 Yes	s 2X No	1	Yes 2	X No	specify			Sp	ecify: Wh	ite
rs after ran", miner	3 Widowed 4	Divorced If Yes, Give or Dates:		16a. Decede	nt's Usual C	occupation	on (Give k	ind of work	done		d of Business	
2 hour "natt	Elementary/Secondary		e (1-4 or 5+)	during n	nost of work	ing life.	DO NOT L	use retired))			
5-0036 ed within 72 hour lygiene. other than "natu the Medical Exan Completed		1		St	udent						ucatio	n
Free Market Property Co.									irst, Middle, M ydia H			
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Philip Gle: 19a. Informant's Name/R			19b. Mailir	ng Address	(Street	and Numi	ber or Rura	al Route Nun	nber, City	or Town, Sta	te, Zip Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatite event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	1	Meske/Fathe	r	1216	1 Flo	wing	Wate	er Tr	ail Cl	larks	ville,	MD 21029
e, V I and J Health item	20a. Method of Disposition	on	20b.	Place of Dispo crematory or o	sition (Nam	e of cen	netery,		ate			or Town, State
nor Pages ent of nt: If	1 Burial 2 XCI	remation 3 Remova		tro Cr	emato:				-2007			le, MD
Baltimore, permit. Pages I an Department of Hed Important: If ite	21. Signature of Funeral		0 M010	22.	Name and	Address	of Facility	Harr	у Н. У	Vitzk	e's Fa	mily FH Inc.
o 50 1 1	Show li	ease, or complications th	at coursed the death	Do not enter	112 O.	1d C	Olum Such as ca	bla P	'IKE EL	LL1CO rest, shock	or heart	Approximate Interval
ysician ledical	failure. List only on	ne cause on each line.		. Do not onto	tilo mode e	. • ,			. ,			Between Onset and Death
⊾xaminer	Immediate Cause (Final or condition resulting in	disease a. Multiple death) a. Due to (or	as a consequence of	of):								1
	Sequentially list condition	ons, b										
iner		iate Due to (or	as a consequence of	of):								
ted less less less less less less less le	(Disease or injury that in events resulting in death		as a consequence of	of):						-		
50, te be executed ysician and burial - transit		d				-						
0, be execut sician and burial - tra	UNPENDED	AMEND	es, outcome of pre	nnanov						23d.	Date of deliv	ery
tal Records, P.O. Box 68760, cian: The law requires that the death certificate be certificate has been signed by the attending physic ector, page 2 should be detached for use as the bure of the completed by Physician/Mar	IF FEMALE: 23b. Was decedent preg past 12 months?	nant in the 1 L	ive birth	2	etal death	3	Ectopic	c pregnanc	су	N	Nonth	Day Year
ox 6 ath cer attendi	1 Yes 2 V No 9	University T	regnant at time of d Inknown	eath 5	Other (Spe	cify)						
). Bc the der the a	Part II. Other significar		ng to death but not	resulting in the	e underlying	cause o	given in Pa	art I.	23e. Did	tobacco u	se contribute	to the cause of death?
P.O.	5		_						1 Ye	es 2 🗸	No 3 P	robably 4 Unknown
Records, The law require ficate has been significate has been significate has been significate has been significated.				-					24a. Was	s an opsy		autopsy findings available to completion of cause of
e law te has te e has te man					<u> </u>				perf	ormed? 2 ✔ No	death 1	? Yes 2 No
		o medical				26.Place		(Check on	nly one)			
Vital ysician ysician director	1 Yes 2	No Hospital:	Inpatient 2	✓ ER/Outpatie		OOA	Other ₄		Home 5	Residen		ther:
ing Physician: The Ling Physician: The Line After this certificate funeral director, page	27 Manner of Death	28a.	Date of Injury Month, Day Year) 20, 2007	28b. Time of 2259 hrs	of Injury		ry at Worl Yes 2 ✔	_ IP	28d. Describe Pedestrian			
tendi death. ctor: y the f	Natural 5 2 Accident	Investigation	Place of Injury - At	1	root factor				28f Location	(Street an	nd Number or	Rural Route Number, City
Division of Vital Records, pital or Attending Physician: The law requiring ours after death. The law free or the service of t		Could not be	ecify) Major Ro			y, onice	bananig, c		or Town	State)		ay, Crofton, Md.
spi		415 day Dhaminiana To th	a hast of my knowle	ndge death oc	curred at the	e time, d	late and pl	lace, and d	due to the ca	use(s) and	manner as s	stated.
To the Hos within 24 h To the Fun completely	(Check only 1 Ger one) 2 Mee	dical Examiner: On the b	asis of examination mer stated.	and/or investi	gation, in m	y opinio	n, death o	ccurred at	the time, dat	te and plac	ce, and due to	o the cause(s)
P · · · · · · · · · · · · · · · · · · ·	29b. Signature and title	of certifier			29		se number	r		1	,	(Month, Day,Year)
	Jasha		1 MB			O.C	.M.E.			April	21, 2007	
Q Jn	30. Name and address of person who complete cause of death (Item 23a) Tasha Greenberg MD — Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201											
Sta		Too the civilians Signature										
Desista	AP	K Z 4 ZUU/	DERBUR	D. D	made	P						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 04 E. 07 Mary Murphey 13 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MEDICAL LENTER DALISBURY KEG10NAL WICIMICO ENINSULA If Under 1 Year | If Under 24 Hrs. | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕱 F Months 63 Director 213-44-1130 5/19/1943 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Snow Hill Maryland Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 or items 23a 301 S. Church St. 21863 USA Completed by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. be filed within 72 hours after on the Hygiene. It and other than "natural", or ite 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify white 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Domestic 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be fili. Department of Health and Mental Hi Important: If Item Z7 Is marked oth any Injury or other traumatic event once. 17. Father's Name (First, Middle, Last) Be Elmer Wilson Ruark Elizabeth E. (unknown) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William E. Murphey III/son 301 S. Church St., Snow Hill, MD 21863 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/20/07 4 Donation 5 Dother (Specify) Salisbury Crematory Salisbury, MD 21. Signature of Funeral Service Dicenses 22. Name and Address of Facility Holloway Funeral Home Professional Association Herle 1 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 266217 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner hours Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit that initiated events and resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 ☐ Unknown Clostridium D.C. 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Cellulti 24a. Was an has page 2 autopsy COPD certificate 2 No 1∐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 ☐ Yes 2 ☐ No 1 Impatient 2 ER/Outpatient 3 DOA Certification: To 5 ☐ Residence 6 ☐ Other (Specify) this nours after death. neral Director: After this y filled in by the funeral di 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated

313441130

State Registrar

DHMH 17 Rev 1/2001

Carroll Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007 4

32.

relde.

29c. License number

140064534

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day}**2007** Physician April 21, George W. Owens (4:06 A. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Northampton Manor Health Care Frederick Frederick If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | 8. Date of Birth | (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F 84 409-26-1785 Director December 24,1922 Tennessee Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylk Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. Tennessee Monroe Sweetwater 1 XYes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 524 Old Highway 68 37874 **USA** Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No f Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No white þ Specify: 3 ☐ Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) designer and manufacturer 10 moldings 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Washington Owens Elizabeth Neil ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Windsor – daughter 2 Sylvia Circle, Thurmont, Maryland 21788 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Mt. Olivet Cemetery 4-23-2007 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Inconsee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland lue 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cerebrel Vascalan months /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine lor Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 2□No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ FAILURE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performe 1□ Yes 2 7 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 29a. Certifier 1 🗆 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of pertific 29d. Date signed (Month, Day, Year) 4-23-07 026499 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

Ronald E. Miller

31. Date filed (Month, Day, Year)

APR 2 4 2007

Division or Vital Records, P.O. Box 68760,

4 Culwell Drive, Mt. Airy, Maryland

32. Registrar's Signature

Glaser

				nent of Health and	-	_	
	1 - For State Registrar			cate of Death	Reg.	No.2007	14702
Physician /Medical	1. Decedent's Name (First, Middle, Las Calvert O. Parks				2. Date of Death Month April 15,	^{Day} 2007 Year	3. Time of Death 6:15 p M
Examiner	4a. Facility Neme (If not institution, give		4b.	City, Town, or Location of Deat	h	4c. County of Death	
Funoval	2407 Lakesville-0		last birthday) ff U	21626 Inder 1 Year If Under 24 Hrs		Dorche 9. Birthp	
Funeral Director	213-24-4538 Usuel Residence of Decedent	M 2□ F 77	Yrs. Mor	ths Days Hours Min.	Nov. 14,	1929 Mary	lace (State or Foreign htty) y Land
Maryland Maryland Items	10a. State 10b. County Maryland Dorches		y, Town or Location Cr	apo		1	0d. Inside City Limits
with the Markin the markin the neutrino	10e. Street and Number 2407 Lakesville-Cr	ano Rd	10	f. Zip Code 21626	10g.	Citizen of What Coun	itry?
uter death v	11. Marital Status	12. Was Decedent Ever in U.	S. 13. Was D	ecedent of Hispanic Origin? (S specify Cuban, Mexican, Puer	specify Yes or No-	14. Race - Americ	
036 ours after al', or its	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		specify Cuban, Mexican, Puer es 2 No Specify:	to Hican, etc.)	Specify:	etc. White
5-0 72 ho	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Decedent's (Give kind o	Usual Occupation of work done during most of wo. OT use retired)	rking 16b	. Kind of Business/Inc	•
21215-0(ed within 72 ho ygiene. ner then "neture it, the Medical Completed	Elementary/Secondary (0-12)	Colfege (1-4or 5+)		oruse retired) :/carpenter		shellfish constructio	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Dependent of Health and Mental Hygiene. Dependents of Health and Mental Hygiene. Say injury or other traumatic swant, the Madical Examinar monat be notified at some. To Be Completed by Funeral Director	17. Father's Name (First, Middle, Last) Robert Joshua Par	:ks	, na cerman	18. Mother's Nar	me (First, Middle, Main	den Sumame)	
Mary d 2 shou tith and M 17 is mar traumat	19a. Informant's Name/Relationship (7) Nancy Holliday Par			tress (Street and Number or Rickesville-Crape			
Ore, ges 1 an i of Heal if item 2 or other	20a. Method of Disposition 1 Burial 2 Cremation 3	20b. P	lace of Disposition emetery, crematory	(Name of or other place)	Date 200	c. Location - City or To	wn, State
altim mit. Pag pertmen sortant: / injury	4 □ Donation 5 □ Other (Specify 21/Signature of Funeral Softwice Licen			lemorialPark 4/ and Address of Facility and Bromwell Fu		Cambridge,	Maryland
g gggg	Coccer Force	L- Demil	308	High St., Camb	ridge, MD	21613	
Physician /Medical	23a. Part1. Enter the Nicease, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	one cause on each line.	nul	mode of dying, such as cardia	c or respiratory arrest,		Approximate Interval Between Onset and Death
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Due to (or as a consect	uanda of):				
760, tte be executed tysicien and he burial-transit cal Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consequence of the consequ	uence of):				
Division of Vital Records, P.O. Box 687 To the Hospital or Attanding Physician: The law requires that the death certificate within 24 hours after death. The Funarial Director Attent this certificate has been signed by the attending phys completely tilled in by the tuneral director, page 2 should be detached for use as the Medical Certification: To Be Completed by Physician/Medic.	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown	death 3 Ector	oic pregnancy or (specify)		23d. Date of delive Month	ory Day Year
ds, P. Jires that signed by d be deta	Part II. Other significant conditions of	ontributing to death but not res	ulting in the underly	ing cause given in Part I.	23e. Did tobac 1 ☐ Yes	co use contribute to the	ne cause of death?
I Record The law requir cate has been s page 2 should					24a. Was an autopsy performer	prior to cor death?	psy findings available
Vital Fision: The certificate rector, page Col	25. Was case referred to medical			26. Place of De	1 ☐ Yes 2 🖟 ath (Check only one)	No 1 ☐ Yes	2 LPU NO
of Vi hysich his cer I direct	examiner? 1 🗆 Yes 2 🖟 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3[04	lome 5 Residence	e 6 ⊡Other (Specify	v)
Ision of ttending Phys death. stor: After this the funeral di	27. Manner of Death 1 Naturaf 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how i	injury occurred	
Division of Vital Remains Physician: The within 24 hours after death. To the Funeral Director: After this certificate in completely tilled in by the funeral director, page Medical Certification: To Be Com	3 Suicide 6 Could not be determined	28e. Place of friury - At he building, etc. (Specify	ome, farm, street, fa	actory, office	28f. Location (Stree City or Town, S	t and Number or Rura itale)	l Route Number,
the Hospi thin 24 hour the Funer impletely till	29a. Certifier 1 Certifying Phyone) 2 Medical Exam	ysician: To the best of my kno iner: On the basis of examina and manner stated.	wledge, death occu tion and/or investig	arred at the time, date and place ation, in my opinion, death occu	a, and due to the caus urred at the time, date	e(s) and manner as st and place, and due to	ated. the cause(s)
To the within To the comp	29b. Signature and title of certifier	. 1		29c. License number	29d.	Date signed (Month,	Day, Year)
	30. Name and address of person who o		1 23a) (Type, Print)	URN ST. ST	E#2 (KM	BRIDGE MO	21613
State Registrar	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture		, , , , , , , , , , , , , , , , , , , ,	51100 119	~ : W! 12"

DHMH 17 Rev 1/2001

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Αn	nend it	em	1 State Registrar #10b per F 1. Decedent's Name (First, Middle, La.	H/wichd/4-	24-07	/d1s	illicate of	Dealli		2. Date of Dea	Reg. No	.C U 13	1 3	3. Time of Death	
	Physicia /Medic		Fred L.	Pus	sey					Month April	Da			2025 M	
	Examin		4a. Facility Name (If not institution, giv	e street and number)		,	4b. City, Town, o	r Location of I				. County of De			
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	Funeral			IVM 2□F		st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min.	8. Date of Birth (Month, Day	, Year)	Country)		
uš.	Director		220-12-1210 Usual Residence of Decedent		36					1/21/1	921		lary.	land	-
	yland now at		10a. State 10b. County Worces	stor	10c. City,	Town or Lo	cation						10d.	Inside City Limits	-
	e Mar a-f sh tified	ctor	Maryland Wicom		Sal	isbury	7							1 ☐ Yes 2 XNo	
	or 28	Director	10e. Street and Number				10f. Zip Code				10g. Ci	tizen of What	Country's	?	
	death with the Maryland ims 23a or 28a-f show r must be notified at		7735 Snow Hill E				21804					USA			_
	er de items	Funeral	11. Marital Status	12. Was Decedent 8 Armed Forces?		i. 13. \	Was Decedent of H f Yes, specify Cub	lispanic Origir an, Mexican,	n? (Spec Puerto R	ify Yes or No- lican, etc.)		14. Race - Al Black, W			
0000	72 hours after natural", or ite dical Examine	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	NO		1□Yes 2∏x No	Specify:				Specify:	whit	te	
5	2 hou atura cal E		15. Decedent's Ed	ducation		16a. Deced	lent's Usual Occup	ation		- 1	16b. K	and of Busine	ss/Indust	try	
ב כ	hin 73	ple	(Specify only highest gra	ade completed) College (1-4or 5	+)	(Give life. L	kind of work done OO NOT use retired	during most o d)	of working	9					
7	filed within Hygiene. other than "	Completed	7			Mech	anic					utomoti	ve		
0	I 2 should be filed within 72 hours after death with the Marylar h and Mental Hygiene. I is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	Be (17. Father's Name (First, Middle, Last,)						(First, Middle,	Maider	n Surname)			
<u>Z</u>	ould Men narke	မ	Marion L. Pusey							arsons					_
Nai	12 sh th and 7 is m traum		19a. Informant's Name/Relationship (g Address (Street					,		nde)	
υ -	permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 is marke any Injury or other traumatic once.	_ 1	Mildred L. Pusey, 20a. Method of Disposition	wile	20b. Pla	ace of Dispo	Snow Hi	1	, Sa Da			ocation - City		. State	-
	Pages nent of int: If its iry or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif				natory or other plac Memorial		/23/	07		lisbury			
altimol	permit. Pag Department Important: I any Injury c		21. Signature of Funeral Service Lice	-	Pa:	rk	Name and Addre					-	•		-
Ď	permit. Depart Import any Inj once.		Lall RX	keers, CF	58		Name and Addre	Funera Hill R	g.,	me Pro Salisb	ies: urv	sional , MD 2]	Asso 1804	ociation	
Ü	A STATE		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plicatio that caused	the death.						-	11.7	Ac	proximate terval Between	
	Physician	10 1	Immediate Cause (Final disease or condition	AS		10								nset and Death	
ž.	/Medical		resulting in death)	Due to (or as a	a conseque	ence of):		1.	,	1	-		1		
	Examiner	_	Sequentially list conditions,	b. Was	tre	inte	etina	13	lle	ding	•				_
1	ed isit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a conseque	ence of):									
	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	CDue to (or as a	a conseque	ence of):							-		
20	cate be executed oblysician and the burial-transit	dical E	(d											
00	ificate g phy as the	edic		-u.											
Š	The law requires that the death certificate to has been signed by the attending physionage 2 should be detached for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 □ Live birth			Ectopic pregnanc	v				23d. Date of	•		
-	e deal he att ed for	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at 9☐Unknown			Other (specify)					Month	Da	y Year	
г Э	at the	Phy	9 Unknown			iai — i — al- — · ·	4-4-1			OG Dida			A - Al	ause of death?	
Ś	ires the signed	þ	Part II. Other significant conditions	contributing to death bu	it not resul	ung in the ur	idenying cause giv	ren in Part I.				use contribute		4	
ecords,	requi	Completed													-
2	e law has t	mp(24a. Was		24b. Were prior death	autopsy to comple	findings available etion of cause of	
l la	n: Th ficate r, pag		OF 144							1□ Yes	2 P No		es 2[□No	-
=	Physiclan: r this certific ral director,	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2₺ No	Hospital:	nt 2 🗆 C	R/Outpatien	t 3 DOA Oth	or		(Check only o		a ====================================			-
5	r Phy er this eral d	: To	27. Manner of Death	28a. Date of Injur	ry	28b. Time of	1 3 DOX	4 🗆 Nurs		Bd. Describe h		6 □Other (S	pecify)		
5	nding tth. r: Afte e fune	atior	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(<i>Month</i> , <i>Day</i>	/ Year)	Injury		rk? Yes 2 □ No	0						
<u> </u>	Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		ry - At hon	ne, farm, str	eet, factory, office		28	3f. Location (S City or Tou		nd Number or	Rural R	oute Number,	
5	ital or rs after ral Di	Cerl		3,		·									
	Hosp 4 hou Funel	edical	(Check only 2 Medical Example 12 Medical Example 2 nysician: To the best ominer: On the basis of	examinati	rledge, death on and/or in	n occurred at the tivestigation, in my	me, date and opinion, death	place, ar	nd due to the d at the time,	cause(s date an	s) and manner and of place, and of	as state	ed. e cause(s)		
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending to completely filled in by the funeral director, page 2 should be detached for use as	Medi	one) 29b. Signature and title of certifier	and manner sta	ited.		29c. Licens					ate signed (Mo			-
	N N N		and the order of the order	33	D	D		11-7 4	413		4	1/9/	1 -	1	
/	14,0		30. Name and address of person who	completed cause of de	eath (Item	23a) (Type	1.	~ //	- 1 5			111	0 ,		_
	114		simona Eng					Ma	1.21	801					
	Sta	ite	31. Date filed (Month, Day, Year)	2007 32. Registra	ar's Signati	ure	ballisbury	1 1.10		30/1					
	Registr	ar	nrn & 4	Alver	w ,	15 B	santi								_

Matthew Bruce Peterson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2007 14704

Physician/ 1. Decedent's Name (First, Middle,Last) Examiner Matthew Bruce 4a. Facility Name (if not institution, give street and number)	2. Date of Death Month Day Year 0952 hrs
1100011011	
4a. Facility Name (if not institution, give street and number)	Peterson April 26, 2007 4b. City, Town, or Location of Death 4c. County of Death
6408 3rd Street	Chesapeake Beach Calvert
7. Age (In vrs. last bin	rthday) If Under 1 Year If Under 24Hrs. 8, Date of Birth(MM/DD/YYYY) 9, Birthplace (State or Foreign
Funeral 3. Social Security Names	Yrs. Months Days Hours Min. 09/04/1983 Country) Michigan
273 30 0000	
Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	n or Location 10d. Inside City Limits
	apeake Beach
Maryland Calvert Chesa	10f. Zip Code 10g. Citizen of What Country?
pur les son les les les les les les les les les les	20714
the second state of the se	13 Was Decedent of Hispanic Origin? (Specify Yes or No-
The second of th	if Yes, Specify Cubari, Wexicari, 1 deric 1 desir, 1 deric 1 deric 1 desir, 1 deric 1
The second of th	1 X Yes 2 No specify: Specify: White
To Dates: 15. Decedent's Education (Specify only highest grade completed) 16a	a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Elementary/Secondary (0-12) College (1-4 or 5+)	7
75 Hill Hill Hill Hill Hill Hill Hill Hil	Delver
98 On the secondary (0-12) 15. Decedent's Education (Specify only highest great and the later than the later t	18.Mother's Name (First, Middle, Maiden Surname)
12 17. Father's Name (First, Middle, Last) We will be the within 3 of the control of the contro	eterson Tina Marie Huron 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Tipe of Maryland Carvert College (1-4 or 5+) College (1-4 or 5+)	27180 Carpenter Drive, Mechanicsville, MD 20659
Cultural IIII H. Onipencery	ce of Disposition (Name of cemetery, Date 20c. Location - City or Town, State
20a. Method of Disposition 20b. Place 20b. Place 20cremation 3 Removal from State	natory or other place)
1 X Burial 2 Cremation 3 Removal from State X Burial 2 Cremation 3 Removal from State Char	les Memorial Grd. 5/3/2007 Leonardtown, MD
21. Signature of Funeral Service Licensee	22. Name and Address of Facility Brinsfield-Echols Funeral Home, P.A. 30195 three Notch Rd., Charlotte Hall, MD 2062
m ad I ii	Approximate interval
failure. List only one cause on each line.	Death
	Irus (Methodone and cayouluse) intradication
or condition resulting in death) Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	4.19.1
cause. Enter Underlying Cause [Disease or injury that initiated] [Disease or injury that initiated]	
events resulting in death) Last	
ddd	
6 5 5 1 2 1 1 UNPENDED 1 7 77 73 7 1 1	perME, G867, 5/16/07 TT 23d. Date of delivery
1 F FEMALE: 23b. Was decedent pregnant in the past 12 months?	ncy 2 Fetal death 3 Ectopic pregnancy Month Day Year
past 12 months?	
You have the part of the part	utting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
Part II. Other significant conditions contributing to death but not resu	ulting in the underlying cause given in Part I. 1 Yes 2 V No 3 Probably 4 Unknown
Part II. Other significant conditions contributing to death but not result for the significant conditions contributing to death but not result for the significant conditions contributing to death but not result for the significant conditions contributing to death but not result for the significant conditions contributing to death but not result for the significant conditions contributing to death but not result for the significant conditions.	24a. Was an 24b. Were autopsy findings available
ords, w require is thought of the control of the co	autopsy prior to completion of cause of
Records, The law requires ficate has been significate has been significant has been significa	performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
9 a section of the se	26.Place of Death (Check only one)
DIOR THE PROPERTY OF THE PROP	R/Outpatient 3 DOA Other Nursing Home 5 Residence 6 ✓ Other Scene
You will be solved by the second of the sec	28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred
Subject of the control of the contro	Fnd 9:45 am 1 Yes 2 X No unk
2 Accident Investigation 28e. Place of Injury - At hom	me, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City
The state of the s	
	e, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
29a. Certifier 1 Certifying Physician. To the best of my knowledge	id/or investigation, in my opinion, death occurred at the time, date and place, and date the Decivious
Set 47 unit and the best of my knowledge (Check only one) 2 Medical Examiner: On the basis of examination and and magner stated.	
E 4 1 2 3 Certifying Physician: To the best of my knowledge (Check only one) 2 Medical Examiner: On the basis of examination and	25t. Elderide Hamber
Se Hart 1 1 29a. Certifier 1 Certifying Physician: To the best of my knowledge (Check only one) 2 Medical Examiner: On the basis of examination and and magner stated. 29b. Signature anotitile of certifier	O.C.M.E. April 29, 2007
30. Name and address of person who completed cause of death (Item 2	O.C.M.E. April 29, 2007
2 290. Signal of the control of the	O.C.M.E. April 29, 2007

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 11:10 PM Aida P Reantoquio April 16 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Frederick Frederick Memorial Hospital Frederick
If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex . Age (In vrs. last birthday Birthplace (State or Foreign) **Funeral** Months Days Hours Min. 1 □ M 2 XF 64 12/26/1942 Director Phillipines 211-48-8039 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County Frederick 1X Yes 2 No MD Frederick Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number or be 21704 ŬSA 9051 Clendenin Way r items 23a c Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. Assist 1 fleam 27 is marked other than "natural", or items 23s and: If item 27 is marked other than "natural", or items 23s any or other traumatic event, the Medical Examiner must. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ▼ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: Asian 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cosmetologist private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unknown unknown ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rowena Rumingan/Daughter 9051 Clendenin Way, Frederick, MD 21704 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages
Department of Important: If it
any injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/28/07 Ft. Lincoln Cem. Brentwood, MD 22. Name and Address of Facility Ft. Lincoln Funeral Home 21. Signatur Funeral Service Licenses 3401 Bladensburg Rd. Brentwood,MD 20722 23a. Part 1. Inter the disease shock, or heart failure. ritications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Immediate Cause (Final Physician resulting in death) /Medical s a consequence of); Examiner euhona Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examin To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as attending | for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has perform certificate Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident I Director: d in by the f 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

within 24 hours after To the Funeral Di completely filled ir

🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

MDD64782

29d. Date signed (Month, Day, Year)



Jens 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tanuja Mishra 172 Thomas Johnson Dr. #202 Frederick, MD 21702

31. Date filed (Month, Day, Year)
APR 2 4 2007 State Registrar

29b. Signature and title of certifier

Medical



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician F. Ragsdale Shirlev Apri1 17, 2007 5:05 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 8. Date of Birth
(Month, Day, Year) Frederick Frederick Memorial Hospital Frederick If Under 1 Year | If Under 24 Hrs.

Vonths Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthdav) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 X F Months 1922 Virginia 85 228-14-9459 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 □Yes 2X No Director Maryland Frederick Frederick 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7407 Willow Road 21702 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No White Maryland 21215-0036 Specify: þ 3 N Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene. 7 **Is m**ar**ked other than "**I Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 Is marked any linjury or other traumatic evance. ပ Glern Ray Francis <u>Julia Stephenson</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Clark Ragsdale / Son 43030 Northlake Blvd., Leeseburg, VA 20176 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Stauffer Crematory Frederick, Maryland 4/19/2007 | Frederick, I ity Stauffer Funeral Home 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 1621 Opossumtown Pike, Frederick, MD 21702 23a Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a phisequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examiner The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): Physician/Medical the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for Month in the past 12 months? 1 ☐ Yes ☐ NO 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has autopsv perform 1 ☐ Yes 2 ☐ No 1200001 1□ Yes 2√ No 25. Was case referred to medical examiner?

Yes 2 No Be director 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2□ No 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1001 115/07 1 ☐ Yes 2 📉 Wo ound .05 **Accident** 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - Al home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician: after death Director: 124 hours after de le Funeral Directo pletely filled in by t To the within 24
To the I

Home Wood 40 Nussing Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 300 West 9th Street, Frederick, MD 21701 Casper Cline, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year)

State Registrar

Medical

APR 24 2007 Rower H. Brank

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Month 1. Decedent's Name (First, Middle, Last) 2. Date of Death Yea C **Physician** NON AIN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🛣 F Hours Director 22, pril 2007 Maryland Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hylgene. Important: If then 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 21740 Funeral 11840 Walnut Point Road USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No 3altimore, Maryland 21215-0036 Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 0 0 None 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဥ Trenton Allen Rowles Christy McClain 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Trenton A. Rowles - Father 11840 Walnut Point Road, Hagerstown, Md. 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/27/07 Rose Hill Cemetery Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home K-Vesta 415 E. Wilson Blvd. Hagerstown, Maryland 21740 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Omblications disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner encephalot Hourd Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Hours Sulmonar Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 | Yes 2 No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed; 2 No 2 No Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, Be (26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 Yes 2 No 1 ☑ Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Matural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 M.O 43225 April 25, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Madhu Nigam, MD Shady Grove Adventist Hospital, Rockville, Md. Year) 31. Date filed (Month, Day State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Jr. Corbett Benona Robbins 02091M 07 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner KEGINHAL MEDICAL CENTER SAUSBURY Wicomico RULZWINZ If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Nov. 16, 1929 Mary Land 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1 M 2 F 215-26-5117 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 28a-f shov 1 □Yes 2 No permit. Pages 1 and 2 should be filed within 72 hours after death with the Mary Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sh any injury or other traumatic event, the Medical Examiner must be notified a once. Dorchester Crapo MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number **USA** 21626 3118 Robbins Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 🏋 No Specify: White Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) County Road Equipment Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Andrews Corbett B. Robbins, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3118 Robbins Road, Crapo, MD 21626 Nancy Robbins Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4/23/2007 Robbins, MD Sandy Island 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Thomas Funeral Home, 700 Locust Street, Cambridge, MD 21613 21. Signatury Funeral Service Licensee 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of) Box 68760, Physician/Medical attending properties for use as SS IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) Ö been signed by the should be detached 9□Unknown مَ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 4 Unknown 2 No 3 Probably 1 TYes 24b. Were autopsy findings available prior to completion of ause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has l page 1 KKILLATION certificate Division or Vital or Attending Physician: as case referred to medical examiner? 26. Place of Death Check onl one funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes € No ို After this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the f 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EASTEKIN SHORE PK, State

Registrar

			For State	State of	f Marylan		artment of F rtificate of	lealth and M		< U	07	14709	
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$\mathcal{M}_{\mathcal{A}}$ r Baltimore,			4 ☐ Donation 5 ☐ Other (Special Service Li			rk		4/24		Salisbu			
Ba	permit. Departr Importe any inje		Signature of Fulleral Service Li	Kleiner	(FS)	0 5	olloway ol Snow	Funeral H Hill Rd.,	ome Prof Salisbu	fessiona ury, MD	al As 2180	sociation 4	
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587	phys phys s the	dical		d									
×	Physician: The law requires thet the death certificities certificate hes been signed by the attending trail director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo						23d Date	of deliver		
Вох	seath atter	ciar	in the past 12 months?		rth 2 ☐ Fetal ant at time of de		Ectopic pregnancy Other (specify)	,		Mor		y Day Year	
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ita	lan: rtifice ctor, j	Bec	25. Was case referred to medical examiner?					26. Place of Death			103		
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	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	Medical	(Check only 2 Medical Ex	caminer: On the ba	sis of examinat	ion and/or inv	estigation, in my o	ne, date and place, a pinion, death occurre	and due to the ca ed at the time, da	iuse(s) and mar ite and place, a	ner as sta nd due to	ted. the cause(s)	
	To the within 2 To the complet	ž	29b. Signature and title of certifier	1//			29c. License	e number	Q 29	9d. Date signed	(Month, D	lay, Year)	
	2 2110		1100	127			0	2974	/	4/20	(d) +	7	
- 3	2/14		30. Name and address of person wi	no completed cause	of death (Item	23a) (Type, F	Print)		(1	7		
			WILLIAM ROBINS				, SALISBU	JRY, MD.	21804				
	Sta		31. Date filed (Month, Day, Year) APR 2 4	2007	gistrar's Signat	ure	- 1						
	Registr	ar	AII N ±	-001	new 1	1 Age	BALL						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2007 Day Month **Physician** ERESA APRIC 30 2030 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL HOPKINS JOHNE BALTI MOUS If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Days Months 1 ☐ M 2 🔀 F Hours Director 214-82-1994 43 15 June 1963 Maryland Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 'natural", or Items 23a or 28a-f shov dical Examiner must be notified at 1 Yes 2 No Director MD Kent Betterton 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 309 Main St. 21610 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) District Court al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) County Clerk 12 Kent County MD 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H Is marked otl Be Franklin R. Allen Beulah Mae East ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Calvin F. Shelton (husband) 309 Main St. Betterton, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 iment of F rtant; If Itr ò 1 ☑ Burial 2 ☐ Cremation 3 Removal from State Department of Important: If any Injury or once. Still Pond Cemetery 5/4/07 Still Pond, MD. 4 Donation 5 Dother (Specify) 21. Signature of Runeral Service L 22. Name and Address of Facility
Galena Funeral Home of Stephen L L. Schaech 21635 M00510 118 West Cross St. Galena, MD. 23a. Part 2 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart pailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in deat EREBERT EDEMA **Physician** 3 DAMS /Medical Due to (or as a consequence of): xaminer STRORE 3 Drys Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) Examiner 3 should law requires that the death certificate be executed -Ancen burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physiclan/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 Yes
9 Unknown Month Year Dav 4□Pregnant at time of death 9□Unknown 5 Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Vnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy perform certificate To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA P 1 npatient eral Director: After thi 28a. Date of Injury 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated: 29b. Signature and title of Pertifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

Horn B. Grante

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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ORIGINAL

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HOSPITAL

20/07

			1 - For State Registrar	State of	f Marylan	-		t of H	ealth a	and M	lental Hy	giene Reg. No.	100/	man or a second	
			1. Decedent's Name (First, Middle	, Last)							2. Date of De Month	ath Day	Year	3. Time of Death	
	Physici: /Medic		Susie	L. Snoot	S						April	'	2007	5:00 A M	
	Examin		4a. Facility Name (If not institution	give street and nur	nber)		4b. City,	Town, or	Location	of Death			County of Deat		
			Brighton Gardens of Tuckerman N. Bethesd										Montgom		
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🛣 F	7. Age (In yrs. I		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th y, Year)	9. Birti Co	hplace (State or Foreign untry)	
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21215-0036	within 72 hours after death with the Maryland ene. Itan "natural" or itema 23e or 28a-f ahow he Medical Examinar must ke notified at	ed	15. Decedent	's Education		16a. Dece	dent's Usua	I Occupa	ition			16b. Ki	nd of Business/	Industry	
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212	r tha	E	12	College (1	1-401 3+)	Admi	nistr	ativ	e Su	perv:	isor	Mod	el Basi	n	
ğ	othe ant,	Be C	17. Father's Name (First, Middle,	Last)					18. Moth	er's Name	(First, Middle	. Maiden	Sumame)		
Maryland	Ald by Al	To B	Joshua Ly	nch					Th	e1ma	Lee	Good	ing		
a	Short and N		19a. Informant's Name/Relations	nip (Type, Print)		19b. Mailir	ng Address	(Street a	ind Numb	er or Rura	al Route Numb	er, City o	r Town, State, 2	Zip Code)	
Σ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Heelth and Mental Hygiene. Depertment of Heelth and Mental Hygiene. Interpretant: If Item 27 is marked other than "natural; or Itema 23a or 28a-f ahow any injury or other traumatic avant, the Medical Examination interpretained at ODGe.		Louise K. Will	iams - Si	ster	2022	5 Geo	rgia	Ave	nue,	Brooke	vill	e, Mary	land 20833	
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Baltimore,	mit.		21. Signature of Fundral Serv	icens 50									eral Ho		
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Division of	ng Pl fter t		27. Manner of Death 1 Natural 5 □ Pendin	28a. Date (Mon	of Injury th, Day Year)	28b. Time o Injury	f 2	28c. Injury at Work? 28d. Describe how injury occurred							
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Ĕ	irect irect	Certification;	3 Suicide 6 Could determ	ined 288. Place	of Injury - At ho ing, etc. (Specif		reet, factory	, office			28f. Location (City or To	Street an wn, State	nd Number or Ri a)	ural Route Number,	
	To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page.		/	1											
	Hosp 4 hot Fune ely fi	edical	(Check only 2 Medical	g Physician: To the Examiner: On the b	asis of examina	wledge, deat tion and/or in	h occurred vestigation	at the tim , in my or	ne, date a pinion, de	nd pl <i>a</i> ce, ath occuri	and due to the red at the time,	cause(s)) and manner as diplace, and due	s stated. to the cause(s)	
	the the the	Med	one) 29b. Signature and title of certifie		ner stated.	<u>-</u>	204	License	number			29d Da	te signed (Mont	h Day Yearl	
)	To Wit		250. Signature and title of certifie	MIN	Ude	7	230	T		360	71.				
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	0		30. Name and address of person						ъ	u1 1	la 36	_1 -	1 20050		
			Ajay Reddy, M	130 E	20 Demod		pou Te.	vard	, Bet	cneso	a, Mar	yıand	1 20852		
	Sta Regist		31. Date filed (Month, Day, Year)	4 2007	agistrar's Signa	13 1	toget!	,							
	3.01			-		/9	-								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** [™]2007 April 19, Marvin Satchwell 8:00 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Frederick Memorial Hospital Frederick Frederick 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1∏M 2□F Days Months Hours Min 404-16-4282 87 Director Jan 13,1920 Kentucky Usual Residence of Decedent iges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene.

If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits Funeral Director Maryland Frederick ¹¶∑Yes 2 No Thurmont 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Colliery Drive 21788 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Black, White, etc. Affiled Folds: 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1940-60 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Completed by Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electronics Engineer Military 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any Injury or other traumatic ev Virgil Satchwell Lu1a Mae Wood ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Satchwell/Wife 6 Colliery Dr. Thurmont, MD 21788 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/16/2007 | Arlington, VA Arlington Nat.Cem 22. Name and Address of Facility Stauffer Funeral Home, PA 21. Signature of Funeral Service Licensee 104 E. Main Street Thurmont, MD 21788 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of) /Medical Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery for 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown significant conditions contributing to death but not esulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No this certificate has page 2 autopsy perform 2 🕢 Hospital or Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ 1 Ampatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred (Month, Day Year) 5 Pending Injury 2 Accident investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director; 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one)

Division or Vital Records, P.O. Box 68760.

State Registrar 2007

[ale m

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Ktrar's Signature

29c. License number

015804

29d. Date signed (Month, Day, Year)

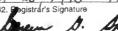
			1 - For State Registrar			of Maryla		artment of H			Reg.	- Z U	07	11:713
	Physici	an	1. Decedent's Name			7				Mo		Day	Year	3. Time of Death
	/Medic Examin		4a. Facility Name (/		ingley, o			4b. City, Town, or	r Location o	Apr f Death	11 2	4c. County	2007 of Death	0630 ^M
					neral Hos			Berli				Wor	ceste	
	Funeral Director	0	5. Social Security N 189-28-4		6. Sex 1 🛣 M 2 🗆 F		. last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. 8. Da	te of Birth onth, Day, Ye . 12,1	ar)	9. Birthpl Count PA	ace (State or Foreign try)
	D		Usual Residence of	Decedent						INOV	. 12,1	337		
	death with the Maryland ims 23a or 28a-f ehow finant be multified at	2	MD No. State	10b. County	ester	10c. C	ity. Town or Lo Berlin						10	Od. Inside City Limits 1 ☐ Yes 2 ☑ No
	the M	Funeral Director	10e. Street and Nur				Dellin	10f. Zip Code			10g.	Citizen of	What Count	
	h with	ai Di	24 Ca	anal Rd				21811	l			USA		
	ems 2	ner	11. Marital Status		12. Was De	cedent Ever in t	U.S. 13. \	Was Decedent of H f Yes, specify Cuba		jin? (Specify Ye , Puerto Rican,	etc.)	14. Rac	ce - America ck, White, e	
36	rs afte	by Fu	1 Never Marri	_	ed 1XXYes If Yes, 0 Year or	; 2 ∐ No Give Dates:		1 ☐ Yes 2 X ☐ No	Specify:			Specif	y: Whit	te
2-00	72 hou natura		(Snec	15. Decedent			16a. Dece	lent's Usual Occup	ation	of working	161	. Kind of B	usiness/Ind	ustry
215	within 7	Completed	Elementary/Seco		Ť	(1-4or 5+)		kind of work done on NOT use retired	d)	or working		Мари	£ > 0 + 111	ai na
7	filed v Hygie other t		17. Father's Name	(First, Middle,	ast)	3	Engin	eer	18. Mother	r's Name (First,	Middle, Mai		factuı ^{ne)}	ring
lan	uld be Mental rked c	To Be	Martin	Wilson	Singley	, Sr.			Edit	h Wood	cock			
Marvland 21215-0036	2 sho	, s	19a. Informant's Na Ann Singl		nip (Type, Print)			g Address <i>(Street :</i> Canal Rd.					State, Zip	Code)
و و	1 and Health tem 27	1 3	20a. Method of Disp			20b.	Place of Dispo	sition (Name of	1	Date	-		- City or To	wn, State
ō	Pages lent of nt: if it ry or o		1 ☐ Burial 2) 4 ☐ Donation		3 □Removal from	n State Ca		natory or other place open Cren		-23-200)7 F	rankfo	ord, [DE
Baltimore.	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural; or Items 23a or 28a-f show any injury or other treumatic event, its Mudical Exams and many be multified at once.		21. Signature of Fu	uneral Service I	icensee			. Name and Addres						ome
	20100		232-Part1. Enter the	he disease, or	complications tha	t caused the dea		108 William of dying a mode of					511	Approximate
	Physician		shock, or hea Immediate Cause disease or condition	Final		ettersi								Onset and Death
9	/Medical Examiner		resulting in death)	,,,	a. Due t		quence of):							4
4	Examiner	35	Sequentially list conditions, b. K. perlipidem a									M		
1002	uted d ansit	Examiner	cause. Enter Unde Cause (Disease or that initiated events	ertying injury	, - M		4							
	rate be executed hysicien and the burial-transit		resulting in death) I	Last	Due t	o (or as a conse	quence of):							
. 4/21/ 68760.	certificate b Iding physic	dica			d									
Box 6	eath certific attending pl for use as t	n/Me	IF FEMALE: 23b. Was deceden	t pregnant		outcome of pregr		JEctopic pregnancy				23d. Da	ite of delive	ry
1637 0. B	g o o	Physician/Medical	in the past 12 1 ☐ Yes 2 [9 ☐ Unknown	□No		gnant at time of		Other (specify)				Мо	onth	Day Year
/2/, P.O.	res that th igned by be detacl	/ Ph	Part II. Other signif		ns contributing to	death but not re	sulting in the u	nderlying cause giv	en in Part I.	23	Be. Did tobac	co use con	tribute to th	e cause of death?
30	= 2°=	ed by									1 ☐ Yes	2 🗆 No	3 Proba	ably 4 Unknown
000	> 0 %	Completed								24	a. Was an autopsy		prior to con	psy findings available appletion of cause of
الم <u>الم</u>	The ate h						_			10	performed Yes 2.12	12~	death?	2□ No
25. Was case referred to medical examiner? 1								t 300 DOA Oth	ar.	of Death Checrising Home 5			or (Coach	Α.
S: 41	두 등 등	H- 1	27. Manner of Deat		28a. Dai	e of Injury onth, Day Year)	28b. Time of				escribe how			,
28-7 28-2 Sion	tending leath. tor: After the funer	catic	2 Accident	investig	ation			M 1 🗆	Yes 2□N					
3 /2	al or At after of 1 Direct d in by	Certification:	4 Homicide	determ	ned 286. Pla	ce of Injury - At I Iding, etc. (Spec	home, farm, str cify)	eet, factory, office			y or Town, S		ber or Hural	Route Number,
Murtin 189	To the Hospital or Attending the Author Safter death To the Funerel Director completely filled in by the	edicai (29a. Certifier (Check only one)	1 Certifyin	Examiner: On the	he best of my kr basis of examinance stated.	nowledge, death nation and/or in	n occurred at the time vestigation, in my o	ne, date and pinion, deat	d place, and du h occurred at th	e to the caus ne time, date	e(s) and mand place,	anner as sta and due to	ated. the cause(s)
	To the within ?	Ň	29b. Signature and	title of certifier				29c. Licens					od (Month, L	Day, Year)
			20 Name	- 1	MD.	1100 of d-14 //-	02a) (T:	D 64				33/0	+	
	BA 10th		20. Name and addr	~	who completed ca	b. 1051	H Rocetr	ack Road	fine	c Be	rliv .	MD	218	11
	Sta Registr		31. Date filed (Mon	nth, Day, Year) APR 2 4	2007	Bigistrar's Sign	nature A	Print) ack Road						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Stete Ragistra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 11:30 P ^M SMITH APRIL 23 2007 **IRENE** HAZEL /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner CHARLOTTE'S HOME WASHINGTON MAUGANSVILLE If Under 1 Year If Under 24 Hrs. Min. April 1 April 24 Hrs. Months Days Hours Min. April 27, 15 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🛛 F Yrs. MARYLAND Director 219-20-2514 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County r than "natural", or Itama 23a or 28a-f ehow the Medical Exempler must be notified at 1 ¥Yes 2 No Completed by Funeral Director MAUGANSVILLE MARYLAND WASHINGTON 10g. Citizen of What Country? 10f. Zin Code 21765 U.S.A. 13725 VILLAGE MILL DRIVE death 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 X Widowed 4 □ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) AIRCRAFT MANUFACTURE 8 **ASSEMBLER** othar 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mantal Hy Important: If item 27 1s marked oth any jinjury or other traumatic evant once. Be ROSA MAE SMITH RALPH FDWARD SHANK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) NANCY J. LOCHNER/DAUGHTER 404 ST. PAUL STREET, BOONSBORO, MARYLAND 21713 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Dengtion 5 Other (Specify) **BOONSBORO CEMETERY** 14/28/2007 BOONSBORO, MARYLAND Puneral X 22. Name and Address of Facility 21. Signature 7606 Old National Pike BAST FUNERAL HOME Paul M. Dean Boonsboro, Maryland 21713 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) YEAR **Physician**) DMENTIA /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or mur) that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The taw requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown 5 Other (specify) 4 Pregnant at time of death ed by the a Ö 9 Unknown 0 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hecords, Completed by 2 No 3 Probably 4 □Unknown 1 ☐ Yes MALNUTRITION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed 2 🗆 No 2 No 1 Yas Division of Vital or Attanding Physiclan: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 0 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural М 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide Hospital within 24 hours a To the Funaral D 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

OBH-L

State Registrar 31. Date filed (Month, Day, Year) APR 2 5 2007 32.



pleted cause of leath (Item 23a) (Type, Print) V

Sperk

1501 CM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Year **Physician** Russell James Speake 2007 Apn ZZ, /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Plata Medical Chartes Center ivista 10 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex Social Security Number **Funeral** Days Months Hours X□M 2□F 76 215-26-3518 Feb. 15, 1931 Washington D.C. Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 1 ☐ Yes 🏋 No Director Charles Waldorf Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 10700 Ashford Circle 20603 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: White 2 3 Widowed 4 Divorced 1952 | 16a. Decedent's Usual Occupation Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Magnete. Elementary/Secondary (0-12) 12 than College (1-4or 5+) Self Employed Restaurant Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maryland Be James D. Speake Beatrice Wooster 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carlita T. Speake Wife 10700 Ashford Circle, Waldorf, Md. 20603 20b. Place of Disposition (Name of cemetery, crematory or other place) April 25,2007 Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chicamuxen United Methodist Chicamuxen, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Williams Funeral Home, P.A. M00668 4270 Hawthorne Rd., Indian Head, Md. 20640 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 6 /Medical Due (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed use as the burial-trar P.O. Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the 9 🔲 Unknown 23e. Did tobacco use contribute to the cause of death? Part I Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. or Vital Records, Certification: To Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 this certificate or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Copatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**5** No 1 ☐ Yes 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral. 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 ☐ Pending investigation Injury 1 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check o 29d. Date signed (Month, Day, Year) 29b. S gnati erson who completed cause of death (Item 23a) (Type, Print) LB 5:1 etchford M.D. 404 E. Charles Street La Plata, MD 20646 harlene A 31. Date filed (Month, Day, Year) 32. Reistrar's Signature State APR 2 4 Registrar 2007

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Mary		artment <i>rtificate</i>			and M		ene) (7	14716	
	Physic	ian	1. Decedent's Name (First, Middle, La	2. Date of Death Month April 1	Day	Year	3. Time of Death							
	/Medi		Susan Banghart Valenstein 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death								· ·		4:15 p м	
7	Exami	ner	5737 Bar Neck Rd.			ridge			4c. County of		ester			
	Funeral		5. Social Security Number 6. S	ex , 7. Age (l.	n yrs. last birthday,	If Under 1	Year	If Under	24 Hrs.	8. Date of Birth				
и	Director		478-24-1529	-1529 1 M 202F 82 Yrs. Months Days Hours Min. Aug. 21, 19								Cal	place (State or Foreign Intry) OWA	
	p z		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location										10d. Inside City Limits	
5	the Maryland r 28a-f ehow	ctor	Maryland Dorches		on only, fount of E	Cambr	idg	e					1 □ Yes 2 ☑ No	
3	death with the me 23a or 28a cmust be noti	al Director	10e. Street and Number 5737 Bar Neck Rd.			10f. Zip 0	Code 2161	3		10	ng. Citizen of W	hat Cou	,	
336 N	hours after deat turel', or iteme	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ➡ ₩idowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 \(\text{Yes} \) 2 \(\text{PNo} \) If Yes, Give Year or Dates:	or in U.S. 13.	Was Decede If Yes, specif	_	spanic Origin, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or No- Rican, etc.)		c, White	ican Indian, , etc. Vhite	
21215-0036	n 72	Completed	15. Decedent's E (Specify only highest gri	ide completed)	(Give	dent's Usual kind of work DO NOT use	done d	uring most	t of worki	ng	16b. Kind of Bus	siness/l	ndustry	
212	d within giene. ir then "	mo.	Elementary/Secondary (0-12)	College (1-4or 5+) 4		Hon	nema	ker			Own !	Home	3	
	be filed ital Hygi od other	Be C	17. Father's Name (First, Middle, Last)				18. Mothe	r's Name	e (First, Middle, N	Maiden Sumame	e)		
<u>yla</u> ı		To	Frank L. Banghar	t						Richards				
Maryland	and and is m	1	19a. Informant's Name/Relationship (**						Il Route Number,				
	lear Hear		John E. Valenste							edericks	20c. Location - 0			
nor	ant of it. If it.		1 ☑ Burial 2 ☐ Cremation 3 E 4 ☐ Donation 5 ☐ Other (Speci		20b. Place of Disponentery, cre Arlingtor									
Baltimore,	permit. Peges 'Department of H Importent: If Ite any Injury or of		21 Signature of Fungral Service Lice										VIIgIliia	
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,1760,	Physician / Medical Examine price and price pric	icai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a ccc. Due to (or as a cccc. Due to (or as a ccccc.	onsequence of):	icer							Onset and Death	
P.O. Box 68	The law requires that the death certifica ste has been signed by the attending phoge 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown										very Day Year	
	uires that signed b	d by P	Part II. Other significant conditions		oot resulting in the o			1	nonar			use contribute to the cause of death?		
ecor	law requ as been 2 shouk	Completed by	Disease							24a. Was ar	24b. W	Vere aut	opsy findings available ompletion of cause of	
=	The law	Con								autops perform 1 Yes 2	ned2 d	eath?	2 🗆 No	
/ita	ician: Th certificate rector, pec	Be	25. Was case referred to medical examiner?	Hospital:			Otho			(Check only one	9)			
of	this aldii	. To	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatient 28a. Date of Injury (Month, Day Y				4 🗆 Nu	rsing Ho	me 5 Reside 28d. Describe ho	ence 6 Other (Specify)			
Division of Vital Records,	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	1 Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not be determined	M reet, factory,		(? /es 2 ☐	No	28f. Location (St	Bf. Location (Street and Number or Rural Route Number, City or Town, State)					
_	Hospital 24 hours a Funerel I etely filled	Medical Co	29a. Certifier (Check only one) 2 Medical Exa	nysician: To the best of miner: On the basis of ex and magner stated	amination and/or in	th occurred a	t the tim	e, date an pinion, dea	d place, th occurr	and due to the ca red at the time, da	use(s) and mai ate and place, a	nner as nd due	stated. to the cause(s)	
_	To the within 2 To the complet	Me	29b. Signature and title of certifier		7	29c.	License	number		25	d. Date signed	(Month	, Day, Year)	
	J P 0		K MY	5/1	to mo		D 4	740	92		April	1	9 2007	
			30. Name and address of person who				1			- 03.563	141		,	
			Jeffrey T. Dento	on, M.D., 55	5 Cynwoo	d Driv	e, E	Easto	n, M	D 21601				
	St Regist	ate	31. Date filed (Month, Pay Year)	2007 32. Registrar's	Signature	South								

DHMH 17 Rev 1/2001

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-03050 State of Maryland / Department of Health and Mental Hygiene Jessica Lynn Vetter Certificate of Death Reg. No. 1- For State Time of Death 2. Date of Death Registrar Decedent's Name (First, Middle,Last) Month Day April 21, 2007 0834 hrs Physician/ Jessica Lyn Vetter

4a. Facility Name (if not institution, give street and number) ' Examiner 4c. County of Death 4b. City, Town, or Location of Death Baltimore University Hospital If Under 1 Year I If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 6. Sex Social Security Number Funeral Hours Months Davs Country) Maryland 1986 Yrs Director 1 M 2XXF 20 215-27-3026 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County iny 1 X Yes 2 No Harford Edgewood 28a-f shov Maryland notified at once, hours after death with the Maryland 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number United States 21040 1704 Fountain Rock Way 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 XNever Married 2 Married 2XX No Yes Specify: White Yes 2 X No specify: If Yes Give Year Divorced 3 Widowed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done ş 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) should be filed within 72 h and Mental Hygiene. Retail Clerk 21215-0036 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joanne Gillin Jeffrey T. Vetter is marked Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1901Pages I and 2 should be ment of Health and Ment lant: If item 27 is mark or other traumatic even 19a. Informant's Name/Relationship (Type, Print) 17 St. Jude's Church Road, North East, Maryland Jeffrey T. Vetter / Father 2 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery 20a. Method of Disposition crematory or other place) Baltimore, Burial 2 X Cremation 3 Removal from State 26, 2007 Newark, Delaware Mayerdale Crematory portant: ury or otl Donation 5 Other Specify 22. Name and Address of Facility permit. Departm Importa 21. Signature of Funeral Service Licensee Crouch Funeral Home Maryland2190 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interva Between Onset and ⁿhysician failure. List only one cause on each line Death 'edical a. Head Injuries Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last 21 and Physician/Medical AMENDED e attending physician a for use as the burial - t UNPENDED To the Hospital or Attending Physician: The law requires that the death certificate be ewithin 24 hours after death. 23d. Date of delivery P.O. Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Year Day 3 Ectopic pregnancy Month 23b. Was decedent pregnant in the Fetal death Live birth past 12 months? Pregnant at time of death Other (Specify) 5 signed by the atte I be detached for u 1 Yes 2 No 9 V Unknown q Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions 1 Yes 2 ✓ No 3 Probably 4 Unknown ۾ 24b. Were autopsy findings available 24a. Was an Completed Division of Vital Records, s been s prior to completion of cause of autopsy death? performed? has No ✓ Yes 2 page 2 26.Place of Death (Check only one) 25. Was case referred to medical Other: Nursing Home 5 Residence 6 Other Be examiner? Hospital: 1 ✓ Inpatient 2 DOA ER/Outpatient 3 this 1 🗸 Yes ဥ 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury Passenger motorcycle auto collision 27. Manner of Death After Apr 20, 2007 Certification: 2056 hrs Yes 2 V No Natural 1 5 Pending the Funeral Director: npletely filled in by the 28f. Location (Street and Number or Rural Route Number, City Investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) York Rd./ Meadow Dr., Timonium, Md. Could not be 3 Suicide (Specify) Major Road / Highway determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical

State

Registrar

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

April 22, 2007

and manner stated

Assistant Medical Examiner

32. Registrar's Signature

TREALING.

30. Name and address of person who completed cause of death (Item 23a)

29b. Signature and title of certifier

Tasha Greenberg MD.

31. Date filed (Month, Day, Year)

Division or Vital Records, P.O. Box 68760,

the Hospital or Attending Physician: within 24 hours aft

To the Funeral Di

completely filled in 🗖 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier APRIL 19, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21701 400 31. Date filed (Month, Day, Year) 32. Registra Signature State 2007▶ Registrar

Registrar
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ORIGINAL

1126_Opal Court, Hagerstown, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kahlid M. Waseem, M.D.

31. Date filed (Month, Day, Year)

			State of Maryland / Dep State of Maryland / Dep Registrar Ce	artment of Health and M <i>rtificate of Death</i>		giene Reg. No.	14720
			Decedent's Name (First, Middle, Last)		2. Date of De Month	ath Day Year	3. Time of Death
	Physicia		Anna M. Whitt		April	21 2007	07:15 PM
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dea	ith
			1862 Appleton Road	Elkton		Ceçi1	
	Funeral		5. Social Security Number 6. Sex 1 □ M 2 1 □ F 7. Age (In yrs. last birthday,	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Bir (Month, Da	th ly, Year) 9. Bit C	thplace (State or Foreign ountry)
	Director		215-34-7059 - 78		April	5, 1929 Wes	t Virginia
	and *	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	f ehow	ō	Maryland Cecil Elkton				1 □ Yes 2√√ No
	the the	rect	10e. Street and Number	10f. Zip Code		10g. Citizen of What C	ountry?
	39 or	Funeral Director	1862 Appleton Road	21921		United St	ates
	me 2	era		Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No	14. Race - Am Black, Wh	
,	or ite	교	Amed Forces? 1 Never Married 2 Married 1 Yes, 3 No If Yes, Green Married 1 Yes, Green Marrie		rican, ec.,	0	
3	reif, c	l by	3 △Widowed 4 □ Divorced Year or Dates:	X			White
	72 h	etec	(Specify only highest grade completed) (GIVI	dent's Usual Occupation a kind of work done during most of work	ring	16b. Kind of Business	s/Industry
4	athin	Completed	Flementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired) emaker		Own Home	
4	tygian tygian ther ti		17. Father's Name (First, Middle, Last)		e (First, Middle	, Maiden Sumame)	
2	t be the train of	Be					
	2 should be filed within 72 hours after death with the Maryland and Mental Hygiane. Is marked other then "naturel; or iteme 23a or 28a-f show sumatic event, the Madical Examinar must be notified at	ပ္	Jesse James Yates 19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ing Address (Street and Number or Rur		er, City or Town, State,	Zip Code)
Ž	d 2 s th an treu treu			Appleton Road, El			1921
נֿע	s 1 and 2 should be filed within 72 hours after death with the Maryla. If Health! and Mental Hygiens 1. Health and Mental Hygiens a fem 23a or 28a-f ehov (fem 27 is marked other then "naturel", or items 23a or 28a-f ehov other treumatic event, the Micalcal Examinar must be notified at		20a Method of Disposition 20b. Place of Disp	osition (Name of	Date	20c. Location - City o	
2	y or of		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	Apri	2007	Calvert, M	arv1and
	permit. Pages 1 and 2 Department of Health a important: if tem 27 is any injury or other tre		Rose Bull			uneral Home	•
Š	Departimon important frame		1/1/2019	27 South Main Stre			
			23a. Dart 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.				Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Cancer			Onset and Death
	/Medical		resulting in death) Due to (or as a consequence of):				1 3 3 3 7 1 7 3
	Examiner		Sequentially list conditions, b.				
	o ti	Examiner	if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury				
	end I-tren	хап	that initiated events resulting in death) Last Due to (or as a consequence of):				
S.	be eg	aiE					
0	ficate phys s the	edicai	d				
ž	certii nding use a	Z/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	□e		23d. Date of d	,
Ď	death B atte d for	Physiclan/Me	in the past 12 months? 4 Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)		Month	Day Year
į	t the by the lache	hys	9 Unknown				
,	s tha	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		tobacco use contribute	
SOLOS,	en si	ted			10	Yes 2□No 3□F	
ວ	as be	Completed			24a. Was	s an 24b. Were a	autopsy findings available o completion of cause of
ב -	The ete h page	ОПО				ormed? death?	s 20146
2	ctan: ertific actor,	Be	25. Was case referred to medical examiner?	26. Place of Dea	th (Check only	опе)	
5	shysi this c	2	1 Yes 2 100 Hospital: 1 Inpatient 2 EF/Outpatie			idence 6 Other (Sp. how injury occurred	pecify)
5	ling P	lon	1 ☐ Matural 5 ☐ Pending (Month, Day Year) Injury	of 28c. Injury at Work? M 1 □ Yes 2 □ No	280. 0030100	now injury occurred	
2/2/2	death death stor:	cat	2 Accident investigation 3 Suicide 6 Could not be determined. 28e. Place of Injury - At home, farm, s		28f. Location	(Street and Number or I	Rural Route Number,
<u>}</u>	or A efter Direct in by	Certification:	4 Homicide determined building, etc. (Specify)		City or To	iwn, State)	
	spita nours nerei		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	ath occurred at the time, date and place,	and due to the	cause(s) and manner	as stated.
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 54 hours elater death. To the Funerel Director: After this certificate has been signed by the attending physician end to the Funerel Director. After this certificate has been signed by the attending physician end compistely filled in by the funeral director, page 2 should be detached for use as the burial-trensit	edical	(Check only 2 Medical Examiner: On the basis of examination and/or and manner stated.	nvestigation, in my opinion, death occui	rred at the time		
	withi To t	Σ	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mo	nth, Deyl Year)
			95 M	D 1 1)00564	149	4/2	3/0/
			30, Name and address of person who completed cause of death (Item 23a) Type	Print Q C	200 E	=11/1 110	2/02/
	ス		31. Date filed (Month, Day, Year) 32. Registrar's Signature	tigh or Juite	JUJ C	- MONIMI) 21/2/
	Sta Registr		31. Date filed (Month, Day, Year) APR 2 3 2007	poerle			
			~ COO!				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. (1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Year Alphonso Adam

4a. Fadility Name (If not institution, give street and number) Adams Mas 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner Northwest Randallstown Baltimore Hospital Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days 212-34-1787 1 № M 2 🗆 F Hours 18/1937 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner miss he marked as 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Pres 2 No Director Baltimore MID 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Fairview 21207 USA 3321 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Yes 2 ☐ Ne
If Yes, Give
Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ NO Specify: þ Specify: 3 Widowed 4 Divorced BIK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Transportation Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Henry Brown Emma 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Batto. MD. 21267 Gloria Adams Wite Fairview 3321 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 5/8/07 King Park Baltimore, mD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Vacuation 21. Signature of Funeral Service Licensee Coseine Funisel Ser. Vaugh C Thethy Rd. Roundallstown Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Anoxic disease or condition resulting in death) Orain /Medical Due to (or as a consequence of): Examiner ardiobulmonary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner burial-transit Intra abdomina
Due to (or as a consequence of): nemorrhage resulting in death) Last Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Hypertension 1 Yes 2 No 3 Probably 4 Unknown Completed Systemic inflammatory 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No response syndrome autopsy performed? Yes 2L2No olon cancerpost resection hronic To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 1 npatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manyer of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 🗌 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

2001m

Bostor

DHMH 17 Rev 1/2001

32. Registrar's Signature

North west

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

Hospital

29d. Date signed (Month, Day, Year)

Center Randallstown,

3 2007

			1- For State of Mary		artment of H		-	giene 200	7 14722
			Decedent's Name (First, Middle, Last)				2. Date of De	ath _	3. Time of Death
	Physici /Medio		Shirley C.	Arant			Month	4 2007	9:44 A M
	Examir		4a. Facility Name (If not institution, give street and number)			r Location of Death	า	4c. County of De	ath
- 2			528 Anderson Avenue 5. Social Security Number 6. Sex 7. Age (i		Rocks	ville If Under 24 Hrs.		Montgom	
	Funeral Director		5.79-34-5437	n yrs. last birthday) O Yrs.	Months Days	Hours Min.	8. Date of Bird (Month, Da October	th ly, Year) 9. B 2 1927 Was1	irthplace (State or Foreign Country) nington, D.C.
	~ ~		Usual Residence of Decedent				OCCODEL	2, 1527 //005	Litigeoni, D.C.
	arylar show d at	7		0c. City, Town or Lo					10d. Inside City Limits
	the M 28a-f iotifle	Director	Maryland Montgomery 10e. Street and Number	Silver	Spring				1 ☐ Yes 2 No
	with yard		3352 Chiswick Court #2G		10f. Zip Code 209	0.6		10g. Citizen of What (-
	death ms 2:	Funeral	11. Marital Status 12. Was Decedent Eve	r in U.S. 13.3	Was Decedent of H If Yes, specify Cuba		pecify Yes or No	United St	aces nerican Indian,
Maryland 21215-0036	ould be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "natural", or items 23a or 28a-f show atic event, the Medical Examiner must be notified at	5	Armed Forces? 1 ☐ Never Married 2 ☐ Married		f Yes, specify Cuba 1 ☐ Yes 2 ☑ No	an, Mexican, Puert Specify:	o Rićan, etc.)		oite, etc. White
5	72 ho natur dical l	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decec	dent's Usual Occup	ation	kina	16b. Kind of Busines	s/Industry
2	vithin ne. han "	mple	Elementary/Secondary (0-12) College (1-4or 5+)	i i	kind of work done o		King	_	
2	filed v Hygie ther t	ပ္ပိ	12 17. Father's Name (First, Middle, Last)	Secur	rity Mana	-	ne (First Middle	Governmer Maiden Surname)	t Contracting
aŭ	ld be ental ked o	To Be	Milton Clark				l Johnso	,	
ary	2 should be filed and Mental Hygin is marked other raumatic event, the	-	19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ig Address (Street			er, City or Town, State	Zip Code)
Σ	and 2 ealth a n 27 is		Christopher D. Arant / Son	528 A	nderson A	Avenue, F	Rockvill	e, Marylan	d 20850
ore	of H of H riter		1 ☐ Burial 2 ☐ Cremation 3 ☐ Bernoval from State		natory or other plac	e) May	Date 7 8,	20c. Location - City of	or Town, State
altimore,	t. Pa rtmen rtant: rjury		4 ☐ Donation 5 ☐ Other (Specify)	Montgomery (Inc. 20	007	Bethesda,	Maryland
Ba	permit. Pag Department Important: I any Injury o	V J	Charles Contract	$1305 \begin{array}{ c c }\hline R01\\300 \end{array}$		phrey Fune gomery Ave			nd 20850-2805
B	J #	ht ii	23a. Part1. Enget the disease, or complications that caused the shock, of heart failure. List only one cause on each line.					rrest,	Approximate Interval Between Onset and Death
	Physician /Medical		resulting in death)	Obstruct	ive Pulme	onary Dis	sease		Shoot and Boats
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		ner	Sequentially list conditions, if any leading to first before cause. Enter Underlying Cause (Disease or injury that initiated events	unsequence of):					-
k V	ecuted nd transit	Examiner							
8760,	cate be executed physician and the burial-transit	E	resulting in death) Last Due to (or as a co	insequence of):					
289		edical	d						
O. Box	the death certificate be executed y the attending physician and iched for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown 23c. If yes, outcome pf pregnant in the past 12 months? 1 □ Live birth 2 □ 4 □ Pregnant at time in the past 12 months in the past	∃Fetal death 3 □	Ectopic pregnancy Other (specify)			23d. Date of do Month	elivery Day Year
٦.	that the		Part II. Other significant conditions contributing to death but no	ot resulting in the ur	iderlying cause give	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?
rds	w requires that the de been signed by the s should be detached	ed by					1 🗆 Y	′es 2□No 3□F	Probably 4 Munknown
Hecords,	sician: The law requires that certificate has been signed b irector, page 2 should be deta	Completed				<u> </u>	24a. Was autop	sy prior to rmed? death?	
VItal	ian: '	BeC	25. Was case referred to medical examiner?			26. Place of Dea		2 ☑ No	s 2 No
or <	Physician: r this certific ral director,	To E	1 ☐ Yes 2 ☒ No Hospital: 1 ☐ Inpatient	2 ER/Outpatient	t 3□ DOA Othe	er: 4 Nursing H	ome 5 Resid	lence 6 KOther (Sp	Son's ecify) Residence
	iding Physician: th. After this certifice funeral director,	ii o	27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, Day Ye	28b. Time of Injury	28c. Injury Work	/ at :?	28d. Describe h	ow injury occurred	
DIVISION	the the	icati	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of injury -	At home farm stre		Yes 2 □ No	29f Location (C	Stroot on all Mounts are as F	Desired Desired Alice Assess
<u>≥</u>	after after i Dire d in b	Certification:	4 Homicide determined building, etc. (S	(pecify)	ot, radioly, dilice		City or Tow	Street and Number or F vn, State)	iurai Houte Number,
	To the Hospital or At within 24 hours after d To the Funeral Directompletely filled in by	edical C	29a. Certifier (Check only one) Medical Examiner: On the basts of examiner on the basts of examiner on the basts of examiner on the basts of examiner of the basts of examiner on the basts of examiner of the basts of examiner of the basts of examiner of the basts of examiner of the basts	amination and/or inv	occurred at the time	ne, date and place pinion, death occu	, and due to the orred at the time,	cause(s) and manner a date and place, and du	is stated. le to the cause(s)
	To the within To the Comp	Me	29b. Signature and title of certifier		29c. License	number	- 2	29d. Date signed (Mor	th, Day, Year)
)	\sim		Bluenere Wholl in		D0064	615		May 4, 200	07
	13		30. Name and address of person who completed cause of death Genevieve Anne Wroblewski, M	.D 1355	Piccard I	Orive, Ro	ckville	, Maryland	
	Sta		31. Date filed (Month, Day, Year) 32 Registrar's	Signature Apple	10				
	Registra	AII	MAY 0 8 2007 Liberar	15 19					

Lerry Brookington 07-03341 Ple UNK UNK

gible.

Please	Type or Print in Bla	ck indelible ink	. Ensure All	Copies Are	Legit
	State of Mandand / I	Donartment of H	lealth and Me	antal Hydiane	

		- For State Registrar	_	Ce	ertificate	of D	eath			Re	9. No.	UU	1 1 4	16
Physicia		Decedent's Name (First, Middle	e,Last)						2.	Date of Deat Month	h Day Yea		3. Time of Death	
ledical Examir	ner	Larry Brocki	naton						- 1	May 2, 200			0118 hrs	
3		4a. Facility Name (if not institutio	n, give street and n	umber)			City, Town, or Lo	ocation of I	Death		4c. County of	f Death		
		921 North Rosedale S	street			1	Baltimore							
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs	. last birthda		f Under 1 Year	If Under 2		8. Date of Birt	h (MM/DD/YYYY			
Director		216-84-6515	1 XM 2 F	31		Yrs.	Months Days	Hours	Min.	01/25	/1976	Cou	Maryland	
	-	Usual Residence of Decedent												
any		10a. State 10b. County		10c. Cit	ty, Town or l	ocation.							10d. Inside City Lin	
nd show	<u>-</u>	Maryland			Ba	alti	more						1 X Yes 2	No
Maryland 28a-f show d at once,	Director	10e. Street and Number				1	0f. Zip Code			10	0g. Citizen of Wh	at Coun	try?	
th the Maryland 23a or 28a-f sho notified at once,	히	3421 Liberty F	Heights A	venue			21215	5			U.S.A.			
with us 23 be no	ᆵ	11. Marital Status	12. Was De	cedent Ever in	U.S. 13		ecedent of Hispa	anic Origin					an Indian, Black,	
death r iter	uneral	1 XNever Married 2 M	arried Armed F	orces?			specify Cuban, I		ruento Ri	ісап, етс.)	White		-	
after all', o	by F	3 Widowed 4 Div	orced If Yes, Give Ye			1 Ye	es 2 X No	specify:		-	Specify:	Bla	ck	
ours		15. Decedent's Education (Spe		de completed)			Usual Occupatio of working life. D				16b. Kind of Bu	siness/Ir	ndustry	
6	Completed	Elementary/Secondary (0-12)	College	1-4 or 5+)		-	ance Wo			-,	UPS De	live	ry Servi	ce
5-0036 iled within 7 Hygiene I other than	Ē	11				.10011					,			
15-C		17. Father's Name (First, Middle,	•				18	8.Mother's	Name (F	-ırst, Middle, I	Maiden Surname	1		
21215-0036 Juld be filed within 72 Mental Hygiene marked other than ic event, the Medical	Be	Larry B. Brock	kington,	Sr.	1405.8	anilian A	Identity (Otto et	Berna	<u>dett</u>	e Bacc	n The City of Tow	o Ctata	Zin Codo\	
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene 27 is marked other than "natural", or items 23a or 28a-f sh maric event, the Medical Examiner must be notified at once		19a. Informant's Name/Relations			19b. N	alling A	duress (Street)	and Numb	er or Ru	rai Route Nun	iber, City or Tow	i, State,	Zip Code 2121	5
구 글 글 표 등	-	Bernadette Bacc	on / Moth	er	34:	21 L	<u>iberty</u> n (Name of ceme	Heigh etery	ts A	ve. F	Saltimor	City or	aryland Town, State	
OTE es la of He of Her t		1 XBurial 2 Cremation	Removal	from State	crematory	or other							Maryland	
Pag Pag ment tant:	L	4 Donation 5 Other Sp	pecify:		_									
Baltimore, permit. Pages 1 at Department of He Important: If ite injury or other tr		21. Signature of Funeral Service	Licensee			22. Nam	ne and Address o	of FacilityT	he T	errick	C. Jon	es F	/H, P.A.	4 -
		23a. Part I. Enter the disease, or	6- 1	an used the doo	th Danata	4611	Park Ho	gts.	Ave.	, Balt	imore,	Mary	land 212	
Physician Medical	ı	failure. List only one cause	on each line.			nter the i	mode of dyllig, s	uuli as uai	ulac of I	espiratory arr	est, strock, or rie	2+1	Between Onset a	
taminer	ĺ	Immediate Cause (Final disease											Death	_
		or condition resulting in death)	Due to (or as	a consequence	e of):									
	ᡖ	Sequentially list conditions, if any, leading to immediate	Due to (or as	a consequence	e of):									
	들	cause Enter Underlying Cause (Disease or injury that initiated	C									- 4		
asit ad	Examine	events resulting in death) Last	Due to (or as	a consequence	e of):									
cecute			d					-						
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and bage 2 should be detached for use as the burial - transit	edical	UNPENDED	AMENDED											
3760, ficate be g physic	ΣI	IF FEMALE: 23b. Was decedent pregnant in the		, outcome of problems		Fetal	death 3	Ectopic p	pregnan	cv	23d. Date of Month		ay Year	
Sox 68 leath certiff attending for use as	l ä	past 12 months?		nant at time of			(Specify)			-,			,	
Box 68 e death certifi the attending ed for use as r	ysi	1 Yes 2 No 9 Un	known 9 Unk	nown										
that the d		Part II. Other significant condit	tions contributing	to death but no	t resulting in	the und	erlying cause giv	ven in Part	tl.				the cause of death?	
, P.O res that t signed by	d by									1Ye	s 2 V No 3	Prob	ably 4 Unkno	wn
ords, w requir	Completed									24a. Was autor			topsy findings avail ompletion of cause	
e faw te has ge 2 s	티	-									rmed?	death?	s 2 No	3
tal Rectian: The certificate ector, page		25. Was case referred to medica	al		_		26.Place	of Death (0	Check or					
of Vital Records, g Physician: The law requir when this certificate has been s meral director, page 2 should l	o Be	examiner? 1 ✓ Yes 2 No	Hospital:	Inpatient 2	ER/Outp	atient 3	DOA C	Other ₄	Nursing	Home 5	Residence 6	Other	: Scene	
n of \ ling Phy After th funeral o	-1	27. Manner of Death	28a. Dat	e of Injury	28b. Tim	ne of Inju	ry 28c. Injury	at Work?			how injury occur	ed		
~ 를 . ^ 리	틸	1 Natural 5 Pen	ullig	th Day Year) 2007	0108 h	rs	1 Ye	es 2 🗸 i	No S	Subject sho	I			
Division fal or Attendi rs after death.	ŝ		stigation 28e. Pla	ice of Injury - At	t home, farm	, street,	factory, office bu	ilding, etc.	. 2			er or Ru	ral Route Number,	City
Division pital or Attent ours after death reral Director:	Certification:			/ Local Str	reet				9	or Town, S 21 North Ro	State) sedale Street,	Baltimo	ore, Md.	
Hospi 24 hou Funci		29a. Certifier 1 Certifying P	hysician: To the b	est of my knowle	edge, death	occurre	d at the time, dat	te and plac	e, and d	lue to the caus	se(s) and manne	r as state	ed.	
To the Hos within 24 h To the Fun completely	Medical	one) 2 Medical Exa	miner:On the basis	s of examination	n and/or inve	estigation	n, in my opinion,	death occi	urred at	the time, date	and place, and	lue to th	e cause(s)	
£ 3 £ 8	₹	29b. Signature and title of certific		n n			29c. License	number			29d. Date sign	ed (Mo	nth, Day, Year)	
		All Bras	nell ils	/			O.C.N	1.E.			May 2, 200)7		
	}	30. Name and address of person	who completed ca	use of death (It	em 23a)						<u> </u>			
		Melissa Brassell, MD	Assistant M	edical Exan	niner 1	11 Pe	nn Street, Ba	altimore	, MD 2	1201				
	ate	31. Date filed (Month, Day, Year)		Registrar's Sign	ature									
Regist	rar	MAY 9 8	2087	AME A	T 19									
DHMH 17 Rev 1/2	001				ORIG	INAL								

07-03053 Donald Lee Barner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

onald Lee Barr		1- For State Registrar		of Death	• •	Reg. No. 200	7 1472
Physicia ledical Examir	ın/	1. Decedent's Name (First, Middle,Last) DONALD LEE		BARNER	2. Date of Dea	ath Day Year	3. Time of Death 0655 hrs
redical Exami	iei	4a. Facility Name (if not institution, give street and number)	<u>'</u>	4b. City, Town, or Location	April 21, 2	4c. County of Daath	
		1807 Village Green Drive		Landover		Prince George	
Funeral Director		220-04-2348 1xm 2F	In yrs. last birthda	y) If Under 1 Year If Under 1		Foreig	thplace (State or on MARYLAND untry)
an y	l	Usual Residence of Decedent 10a. State 10b. County 10	Oc. City, Town or L	ocation			10d. Inside City Limits
Maryland 28a-f show 1 at once.	٥	112	FORESTVI				1 X Yes 2 No
th the Maryland 23a or 28a-f sho notified at once.	I Director	10e. Street and Number 6569 HILMAR DR		10f. Zip Code 20747		10g. Citizen of What Cou	
r death wi or items must he	Funeral	11. Marital Status 1 X Never Married 2 Married 12. Was Decedent Examed Forces? 1 Yes 2 X 3 Widowed 4 Divorced If Yes, Give Yeer	No	B. Was Decedent of Hispanic O If Yes, specify Cuban, Mexica Yes 2 No specif No specif	an, Puerto Rican, etc.)	o- 14. Race - Amer White, etc. Specify: BLA	ican Indian, Black, $ m ACK$
hours afte "natural", Examiner	d by	15. Decedent's Education (Specify only highest grada compl	eted) 16a. Dec	edent's Usual Occupation (Giv		16b. Kind of Business/	Industry
5-0036 led within 72 h Hygiene. other than "n the Medical E.	Completed	Elementary/Secondary (0-12) College (1-4 or 5+ 11th)	UTO SHOP	or use reureu)	PRIVA	ATE
D 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medica		17. Father's Name (First, Middle, Last) DAVID BARNER	· · ·		er's Name (First, Middle,	Maiden Surname)	
21215-(buld be filed v Mental Hygi marked oth c event, the	To Be	19a. Informant's Name/Relationship (Type, Print)	19b. M	lailing Address (Street and No	SIE STEWART umber or Rural Route Nu	mber, City or Town, State	e, Zip Code)
ore, MD ss I and 2 sho of Health and If item 27 is her traumati		DORIS BARNER/SISTER	656	9 HILMAR DR FO	ORESTVILLE,	MD 20747	
imore, MD 2121 Pages I and 2 should be fi ment of Health and Mental i tant: If item 27 is marked or other traumatic event,		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State	crematory	isposition (Name of cemetery, or other place)	Date 5 / 2007	20c. Location - City or RIVERDALE	
Baltimore, ME permit. Pages I and 2 s Department of Health an Important: If item 27 injury or other traum		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	RIVERDA	LE CREMATORY	5-4-2007		
Bal permi Depa Impo injur	ļ	K. D. M. all		22. Name and Addrass of Faci 7474 LANDOVER			JME
Physician		23a. Part I. Enter the disease, or complications that caused th failure. List only one causa on each line.	e death. Do not e	nter the mode of dying, such as	cardiac or respiratory at	rest, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Gunshot Wound to pue to (or as a consequence)		Chest			Death
	ner	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence)	uence of):				
A	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a conseq	uence of):				
executed an and al-transit		d.					
760, cate be execut physician and he burial - tra	Medical	UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome	of preamancy			23d. Date of deliver	
D.O. Box 6876 that the death certificat ned by the attending ph detached for use as the	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 1 Unknown	2	Fetal death 3 Ecto Other (Specify)	pic pregnancy		y Day Y ear
O. B at the de		Part II. Other significant conditions contributing to death t	out not resulting in	the underlying cause given in	Part I. 23e. Did	tobacco use contribute to	the cause of death?
B, P.O.	d by				_	es 2 No 3 Pro	
ords, aw requir as been s	Completed						utopsy findings available completion of cause of
tal Reco	S				1 🗸 Yes		es 2 No
Vital Recysician: The list certificate director, page	Be	25. Was case referred to medical examiner?	2 ER/Outp	26.Place of Deal	th (Check only one) Nursing Home 5	Residence 6 ✔ Othe	er: Scene
ing Ph After t	tion: To	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury FOUND: Day, Yes	28b. Tim	e of Injury 28c. Injury at Wo	— Subject sh	how injury occurred ot	
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:		ry - At home, farm	, street, factory, office building,	or Town,	(Street and Number or Ri State) Green Drive, Landov	
To the Hospi within 24 hou To the Funer completely fil	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my lone) Medical Examiner: On the basis of exami	knowledge, death nation and/or inve	occurred at the time, date and stigation, in my opinion, death	place, and due to the cau	use(s) and manner as sta e and place, and due to t	ted. ne cause(s)
To cor	Me	29b. Signature and title of certifier		29c. License numb	er	29d. Date signed (Mo	onth, Day, Year)
		9 m. lt	<u> </u>	O.C.M.E.		April 22, 2007	
\		30. Name and address person who completed cause of dea Jack Titus MD. Deputy Chief Medical Exa		Penn Street, Baltimore	e, MD 21201		
St Regist		31. Date filed (Month, Day, Year) 32. Registrar's	Signature	tood a			
Drivin 17 Rev 1/20	_	WINT U & CUUI J. Sagar.	ORIG	INAL			

			1 - State of Maryland / D		artment of H		and M		iene	0.7	14725
	Physici		1. Decedent's Name (First, Middle, Last) Annabelle E. Burkins					2. Date of Deat Month	th	0 ^Y 0°7	3. Time of Death 10:25 A
	/Medio Examir	-	4a. Facility Name (If not institution, give street and number) Harford Memorial Hospital		4b. City, Town, or Havre	de	Grad	ce	4c. County	Har	ford
	Funeral Director		5. Social Security Number 212-26-2988 G. Sex 1 M 200 F 7. Age (In yrs. last binth 83 Y Usual Residence of Decedent	hday) (rs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, 7/30/	Year)	9. Birth Cou Per	^{place} (State or Foreign ntry) nnsylvania
	a Maryland	ctor	10a. State 10b. County 10c. City, Town		cation st Hill						10d. Inside City Limits
	th with th	al Director	10e. Street and Number 104 Gwen Dr. Unit L		10f. Zip Code 210	50		1	0g. Citizen of U	What Cou	ntry?
980	2 should be filad within 72 hours after death with the Maryland and Mantal Hygiana. ie marked other then "naturel", or iteme 23a or 28e-f ehow aumatic event, it a Medical Exercitar must be routified at	by Funeral	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Midowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 Xevo Vear or Dates:	1	Was Decedent of Hi f Yes, specify Cubai I ☐ Yes 2 ☑ No	spanic Ori n, Mexican Specify:	gin? (Spe , Puerto	cify Yes or No- Rican, etc.)		ck, White,	can Indian, etc. nite
Maryland 21215-0036	within 72 ho ana. then "natur re Medical	Completed	(Specify only highest grade completed)	(Give life. L	lent's Usual Occupa kind of work done of DO NOT use retired Homemak	luring mos)	t of worki	ng	16b. Kind of B	sider	
/land 2	a a b	To Be Co	17. Father's Name (First, Middle, Last) Sydney Dows		110 memax			(First, Middle, I Lanche	Maiden Sumai	me)	
	12 등 등 명		Cecilia Earle/ cousin F	20	Box 143 sition (Name of	Dar	ling	gton, N		34	
altimore,	Paga nant o		1 Burial 2 ACremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signafure, Funeral Service Licensee	r. cren F	uneral Ai Bel Ai		Мау [°] . 200	78,	Fores	t Hi	ill, MD
Ba	parmit. Departimonte importe any inju		23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	\&	Name and Address rans Fun Cremati er the mode of dying	on S	erv.	ices ^r		Peri	Dr. MD 050 Approximate Interval Between
)	Physician /Medical Examiner			f):	LON CI		N				Onset and Death Months
8760,	cata ba exacutad physician and tha burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence or C. Due to (or C. D	f):	770 CC1 ~						
.O. Box 68	Attending Physician: The law requires that the death certifics ridath. sctor: Atter this cirtificate has been signed by the attending price that funeral director, page 2 should be datached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown		Ectopic pregnancy Other (specify)					ate of deliv	ery Day Year
<u> </u>	w recuiras that been signed by should be data	þ	Part II. Other significant conditions contributing to death but not resulting in	the ur	nderlying cause give	en in Part I.		23e. Did tob	1.0		he cause of death?
Division of Vital Records,	: The law re cate has be , page 2 sho	Completed	Hypertension	(24a. Was a autops perform	y ned?	Were auto prior to co death? 1 \(\text{Yes} \)	opsy findings available ompletion of cause of
=	s certifi director	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: Impatient 2 ER/Out	nation	t 3□ DOA Othe	\r		(Check only on		hor (Conci	6.1
sion of	ttending Phydaath. daath. ctor: Aftar thi y tha funaral o		27. Manner of Death Natural 5 Pending 2 Accident Accident 28a. Date of Injury (Month, Day Year) In		28c. Injury Work		2	28d. Describe ho			
Divis	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, lard building, etc. (Specify)					City or Towr	i, State)		al Route Number,
	To the Hospital or within 24 hours atta To the Funeral Dir complataly filled in I	edical	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, 2 Medical Exeminer: On the basis of examination and and manner stated.	death /or inv	n occurred at the time restigation, in my op	e, date an pinion, dea	d place, a th occurre	and due to the ca ed at the time, da	ause(s) and mate and place.	anner as s and due t	stated. o the cause(s)
)	To t com	₩.	29b. Signature and title of certifier WOUNDO		29c. License	(O (59	7	9d. Date signe	d (Month,	Day, Year)
	\0		30. Name and address of person who completed cause of death (Item 23a) (The Standard	ype.	Print) US NO SS	Cont	cv u	by t	Edge	uvo	0 21040
	Sta Registr	_	MAY 0 8 2007	80				,	(

		1	For State Registrar	Otato of Mar	yland / Dep <i>Ce</i>	ertificate o			Reg. No. 2 0 0	7 1472
	Physiciai /Medica	n	Decedent's Name (First, Middle,	ŕ	tha Barr			2. Date of De Month	ath Day Year May 5, 2007	3. Time of Death 9:45 p
	Examine	er	4a. Facility Name (If not institution,			4b. City, Town	or Location of Dea		4c. County of Dea	th Saltimore
	Funeral Director		5. Social Security Number 242-14-7641	Stella Maris 6. Sex 7. Age (I 1 □ M 2 □ √x	n yrs. last birthda Yrs.	/) If Under 1 Year Months Day	r If Under 24 Hrs	. (Month, Da	th 9. Bir	thplace (State or Foreigountry) No. Carolina
	viand ow at		Usual Residence of Decedent 10a. State 10b. County	10	Oc. City, Town or I	ocation		Dec	, 2, 1321	10d. Inside City Limit
	the Mary 28a-f sh notified	Director	Maryland 10e, Street and Number	N/A		10f. Zip Code	Baltimore		10g. Citizen of What Co	1 X es 2 N
	h with		409 Watty Court			101. 219 0000	21201		•	.S.A.
92		∄	11. Marital Status 1 □ Never Married 2 □ Marrie	If Yes, Give	er in U.S. 13	. Was Decedent of If Yes, specify Cu	Hispanic Origin? (uban, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)	14. Race - Ame Black, White Specify:	te, etc.
21215-0036	72 hours 'natural'' dical Exa	eted by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent' (Specify only highes)	Year or Dates:	16a. Dec	edent's Usual Occ		orking	16b. Kind of Business	Black /Industry
1717	be filed within 72 ho ttal Hygiene. Id other than "natu event, the Medical	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life	DO NOT use reti	Laborer			actory
Maryland	should be filed nd Mental Hygi marked other Imatic event, ti	To Be	17. Father's Name (<i>First, Middle, L</i>	.ast) David Jones			18. Mother's Na	ıme (First, Middle	Maiden Surname) Ariel Jones	
/lar	2 sho		19a. Informant's Name/Relationsh		19b. Ma				er, City or Town, State,	Zip Code)
	1 and Health tem 27 other tu	3	Raymond Barnes S 20a. Method of Disposition		20b. Place of Dis	osition (Name of	er Avenue Ba	Date Date	/land 21239 20c. Location - City or	Town, State
altimore,	Pages nent of I int: if its		1 ☐ Byrial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp			ematory or other p butus Memo		05/10/0	7 Baltimo	re, Maryland
Balti	permit. Pages Department of t important: If Ite any Injury or of once.		21. Signature of Funeral Service L	icensee		22. Name and Add	lress of Facility	ineral Service	e P A	
			23a. 1 art 1. Ent — The disease, or o shock, or — art failure. List o Immediate Cause (Final		V	130 nter the mode of d	p Brothers Fu 0 Eutaw Place ying, such as cardia	e Baltimore, ac or respiratory a	Md 21217 rrest,	Approximate Interval Between Onset and Death
1	Physician /Medical		disease or condition resulting in death)	a. LUNG CANC						
	Examiner	<u>.</u>	Sequentially list conditions,	b. Due to or as a c	onsequence of					
×	ecuted and -transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a c						
68/60,	physician and the burial-transit	dical		d	onsequence ory.					
J. Box 6	death certiff e attending d for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ▼ No 9 ☐ Unknown	23c. If yes, outcome pf 1 □ Live birth 2 [4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	□Ectopic pregnar			23d. Date of de Month	livery Day Year
ς, Σ.	The law requires that the tte has been signed by the tage 2 should be detached.	by Phy	Part II. Other significant condition	ns contributing to death but n	not resulting in the	underlying cause (given in Part I.	23e. Did t	obacco use contribute t	o the cause of death?
ord ord	require been sig							-	Yes 2 No 3 P	robably 4X1Unkno
	The larate has	Completed						24a, Was auto perfo 1 Yes	psy prior to prmed? death?	utopsy findings availa completion of cause of 2 No
<u> </u>	Physician: r this certificaral director, I	Ö	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼ No	Hospital:	2 ☐ ER/Outpati	ent 3□ DOA C	Nale e v	eath <i>(Check only o</i>	one) dence 6 X IOther (Spe	wife HOCDTCE
on or	in the second	- h	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury	28b. Time	of 28c. In			how injury occurred	HOSPICE
	Atter r deal ector by the	Certification:	3 Suicide 6 Could not determine	ot be 280 Place of injury	- At home, farm, s Specify)			28f. Location (City or To	Street and Number or R wn, State)	ural Route Number,
	Hosp 4 hou Fune lely fill	Medical C	29a. Certifier (Check only one)	g Physician: To the best of n Examiner: On the basis of ex and manner stated	amination and/or	ath occurred at the investigation, in m	time, date and plac y opinion, death occ	ce, and due to the curred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Lice	nse number	(29d. Date signed (Mon	th, Day, Year)
,	1.	-	30. Name and address of person v	vho completed cause of deat	h (Item 23a) (Type	e, Print)	1312	1	/ /	5
			DR. TARIQ MAHM	00D 2300 DUL	ANEY VAL	LEY RD.	TIMONIUM	, MD 210	93	

DHMH 17 Rev 1/2001

Physician Division or Vital Records, P.O. Box 68760,

/Medical Examiner To the Hospital or Attending PhysIclan: The law requires that the death certificate be executed burial-transit physician the as for use ed by the a detached f signed by page 2 should the funeral director, After t after death. filled in by within 24 hours at To the Funeral C completely filled

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

Pages 1 and 2 should be filed within 72 hours after death with to nent of Health and Mental Hyglene. Int: If Item 27 is marked other than "natural", or Items 23a or? 7 is marked other than "natural", or Items 23a or traumatic event, the Medical Examiner must be r

other t

Department of H Important: If Ite any Injury or ot once.

altimore, Maryland 21215-0036

Funeral Director

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Completed

Be

if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed 25. Was case referred to medical examiner? Be 1 Yes Certification: To 27. Manner of Death 1 Natural 2 Accident 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) vold M. Koll- MEDICAL DOCTOR RES-000

10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TODD KOLB, THE JOHNS HOPKINS HOSPITAL, 600 NORTH WOLFE STREET, BALTIMORE, MARYLAND, 21287 31. Date filed (Month, Day, Year) ,

State Registrar



ORIGINAL

Physician /Medical **Examiner**

Examiner

Physician/Medical

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Completed

Be

၉

Certification:

Medical

burial-tran and attending physician the cate has been signed by page 2 should be detact After this To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After

Division or Vital Records, P.O. Box 68760.

disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

9 Unknown

20a. Method of Disposition

1 ☑ Burial 2 ☐ Cremation

21. Signature of Funeral Service

23a. Part1. Enter the disease, shock, or heart failure. L

immediate Cause (Final disease or condition

4 Donation 5 Dother (Specify)

Due to (or as a consequence of): IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

19a. Informant's Name/Relationship (Type. Print)

Mary Jane Mekulski/ Daughter

3 Removal from State

23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 4□Pregnant at time of death

Fronto tempora, Due to (or as a consequence of):

Due to (or as a consequence of):

3 Ectopic pregnancy 5 Other (specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Dulaney Valley Mem.

e, ocmplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line.

23d. Date of delivery Month

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

20c. Location - City or Town, State

Timonium, Md.

Day

Approximate Interval Between Onset and Death

cars

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Tinpatient

24a. Was an autopsy performed? 26. Place of Death (Check only one)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1221 Winespring Lane Baltimore, Md. 21204

5-9-07

22. Name and Address of Facility Ruck Towson Funeral Home, 1050 York Rd. Towson, Md.

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

1 ☐ Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide

29a. Certifier

5 Pending investigation 6 Could not be determined 4 ☐ Homicide

28a. Date of Injury (Month, Day Year) Place of injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 3 DOA

28b. Time of

Other: 4 Nursing Home 5 Residence 6 Dother (Specify) PSS & Live 28d. Describe how injury occurred 1 TYes 2 TNo

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Sigrature and title of certifier

25. Was case referred to medical examiner?

29c, License number

28c. Injury at Work?

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles St Tonson no 21204 HARVES NUD 6701 N.

Registrar

dity Name (If not institution, grand Samarital Sacurity Number 68-3662 desidence of Decedent ate 10b. County Baltime 7526 Orlando Refital Status Never Married 2 Married Widowed 4 Divorced 15. Decedent's (Specify only highest grand Sarup Bhand formant's Name/Relationship Samina Bhand Samina Samina Bhand Samina Bhand Samina Bhand Samina Bhand Samina Samina Bhand Samina Samina Bhand Samina Bhand Samina Bhand Samina Samina Bhand Samina Samina Bhand Samina Samina Bhand Samina Samina Bhand Samina Sa	K. Bhandari nive street and number) n Hospital Sex 1 DXM 2 F 67 ore 12. Was Decedent Ever Armed Forces? 1 DYes 2 X No If Yes, Give Year or Dates: Education College (1-4or5+) 5+ st) ari of (Type, Print) dari / Wife	16a. Dec (Giv. life. Tax) 19b. Mai 1520 Db. Place of Discometery, or illtop	Balt y) If Under 1 Ye Months Da Location Ore 10f. Zip Coc 3. Was Decedent If Yes, specify (1 Yes, specify (2 Do NOT use re Xpayer A illing Address (Str 6 Orland position (Name orlematory or other Service 22. Name and Ac Ruc	de 21234 of Hispanic Orig Cuban, Mexican No Specify: ccupation one during most attred) 18. Mothe S reet and Numbe lo Rd. B of place) Co.	of Death 24 Hrs. 8. Day Min. Dec gin? (Specify Ye, Puerto Rican, of working r's Name (First, atyawat or Or Rural Route	e of Birth Man. Year. 10g. Co. 16b. Middle, Maide i Behl of Number, City e, Md. 20c. 1	USA 14. Race - Ame Black, White Specify: Kind of Business If an Sumame)	thplace (State or Foreign 1011a) 10d. Inside City Limits 1
Good Samarital al Security Number -68-3662 Residence of Decedent ate 10b. County d. Baltime Teet and Number 526 Orlando Re Residence of Decedent Teet and Number 526 Orlando Re Residence of Decedent Teet and Number 526 Orlando Re Residence of Decedent Teet and Number Te	n Hospital Sex 1 XM 2 F 67 ore oad 12. Was Decedent Ever Armed Forces? 1 Yes, Give Year or Dates: Education Grade completed) College (1-4or 5+) 5+ st) ari 0 (Type, Print) dari / Wife	Prs. City, Town or I Baltimo in U.S. 13 16a. Dec (Giv. life. Ta) 19b. Mai 1526 Db. Place of Discemetery, crilltop	Balt y) If Under 1 Ye Months Da Location Ore 10f. Zip Coc 3. Was Decedent If Yes, specify (1 Yes, specify (2 Do NOT use re Xpayer A illing Address (Str 6 Orland position (Name orlematory or other Service 22. Name and Ac Ruc	de 21234 of Hispanic Orig Cuban, Mexican in O Specify: ccupation one during most stired) 18. Mothe S reet and Numbe lo Rd. B of place) Co.	gin? (Specify Ye, Puerto Rican, of working r's Name (First, atyawat or or Rural Route altimor Date	a of Birth Maide i Behl Number, City e, Md.	N/A 9. Bir 939 Ti Citizen of What Co USA 14. Race - Ame Black, Whit Specify: Kind of Business If an Sumame) or Town, State, 21234 Location - City or	thplace (State or Foreign 1011a) 10d. Inside City Limits 1
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ntially list conditions, eading to immediate Enter Uniderfying (Disease or injury lated events g in death) Last	b. Myor	nsequence of):	Inf.	farcti	on			Inierval Between Onset and Death
ALE: 'as decedent pregnant the past 12 months? Yes 2 No	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ I 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	B Ectopic pregna				23d. Date of de Month	ivery Day Year
Other significant conditions	s contributing to death but not	t resulting in the	underlying cause	e given in Part I.	23	e. Did tobacco		the cause of death?
						a. Was an autopsy performed? Yes 2X N	death?	utopsy findings availab completion of cause of 2 \(\sum \text{No} \)
Suicide 6 Could not	28a. Date of Injury (Month, Day Yea ion 28e. Place of Injury -	28b. Time Injury	of 28c. I	Other: 4 Number	28d. De	☐ Residence scribe how injustion (Street a	ury occurred and Number or Ri	
ertifier 1 Certifying I	ammer: On the basis of exam	knowledge, dea	ath occurred at th	ne time, date and my opinion, deat	d place, and due	e to the cause(e time, date ar	s) and manner as nd place, and due	s stated. to the cause(s)
	a. ra mannon statou.					20d D	tate signed (Mont	h, Day, Year)
or or	ritier 1 Certifying 2 Medical Ex	ritier Yes 22 No Hospital: 1 □ Inpatient 1 □ Inpatient 1 □ Inpatient 1 □ Inpatient 28a. Date of Injury (Month, Day Yea 28e. Place of Injury building, etc. (St 1 □ Inpatient 28a. Date of Injury (Month, Day Yea 28e. Place of Injury building, etc. (St 28e. Place of Injury 2	Hospital: 1 Inpatient 2 ER/Outpat: yer of Death Natural 5 Pending investigation Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify) Certifying Physician: To the best of my knowledge, desection and/or and/or the basis of examination and/or	Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA rer of Death Natural 5 Pending investigation Suicide Homicide Suicide Suici	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nu Prevent of Death Natural Suicide Homicide Suicide Homicide Suicide Accident: 28e. Place of Injury - At home, farm, street, factory, office Suicide Homicide Suicide Suici	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Injury Attural 5 Pending investigation Suicide Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due and manner stated.	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence per of Death per of Death Natural Accident Suicide Homicide 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No No No No No No No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specific Property of Death North, Day Year) 1 Pending investigation Suicide Homicide 28a. Date of Injury M 28b. Time of Injury M 1 Yes 2 No 28b. Time of Injury M 1 Yes 2 No 28c. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Richt) City or Town, State) 28f. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as leack only and manner stated. 29c. License number 29d. Date signed (Month) 29d. Date signed (Month)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

			For State Registrar	State of Marylar		nt of Health and ate of Death		ne 0 0 7	14730
	Physici	an	1. Decedent's Name (First, Middle, Last)	0.1.			2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	CLEMENTINE 4a. Facility Name (If not institution, give s		O CK	y, Town, or Location of Deal		3 2007 4c County of Death	1 pm M
	Examili	e	6920 BROOK			Baltimore		Boulton	12
	Funeral Director		29 1.90. 4344	7. Age (In yrs.	Month	ler 1 Year If Under 24 Hrs		9. Birthe Cour	lace (State or Foreign try)
	yland Mow		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Location			1	0d. Inside City Limits
	e Man	ctor	MD Baltin	none Bo	altimore				1 ☐ Yes 2 No
	with th	Funerai Director	10e. Street and Number	<i>a</i>		Zip Code	10g	. Citizen of What Cour	ntry?
	ne 23	erai	11. Marital Status	12. Was Decedent Ever in U	I.S. 13. Was Dec	edent of Hispanic Origin? (S	Specify Yes or No-	14. Race - Americ	ean Indian,
920	n 72 hours after death with the Maryland "natural", or liteme 23a or 28e-f ehow solical Extendral be notified at	ρ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 MNo If Yes, Give Year or Dates:	If Yes, sp	pecify Cuban, Mexican, Puer 2 No Specify:	to Rican, etc.)	Specify: Pole	etc. CaCV2
21215-0036	c * @	Completed	15. Decedent's Edu (Specify only highest grade	cation e com <i>pleted)</i> College (1-4or 5+)	16a. Decedent's Us (Give kind of the life. DO NOT	vork done during most of wo	rking 16	b. Kind of Business/In-	dustry
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Maryland		00	Curtis Brannon				Bonner		
lary	2 sh and is m		19a. Informant's Name/Relationship (Ty)	pe, Print)	19b. Mailing Addre	ss (Street and Number or R		ity or Town, State, Zip	Code)
	1 end Health em 27 ther tr	1	hencute Graham 20a. Method of Disposition	1 Daughter	3107 1	orchestr /h		Finiting Mil	
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Вох	death certifii e ettending p id for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregn: 1☐Live birth 2☐Feta 4☐Pregnant at time of c	al death 3 Ectopic			23d. Date of delive Month	ery Day Year
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Division of Vital Records, I	9 P P	ρ	Part II. Other significant conditions con	tributing to death but not res	sulting in the underlying	cause given in Part I.		ccouse contribute to the	ne cause of death? ably 4 Munknown
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DIX	i Dift	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, street, factory)	ory, office	28f. Location (Stree City or Town, S	et and Number or Rura State)	l Route Number,
	Hospital	edicai	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Exemin	sician: To the best of my known or on the basis of examina	owledge, death occurre	d at the time, date and place on, in my opinion, death occ	e, and due to the caus urred at the time, date	se(s) and manner as si and place, and due to	tated. the cause(s)
	To the I within 2 To the I complet	Med	29h Signature and title of certifier	and manner stated.	2	9c. License number	29d.	Date signed (Month,	Day, Year)
	1		> Jean	bs Mi	>	D00615	58	5/4/07	
	10		30. Name and address of person who co	mpleted cause of death (Iter	m 23a) (Type, Print)	, , , , , , , , , , , , , , , , , , , ,		. 1 1 1	
	Sta	10	31. Date filed (Month, Day, Year)	ST Kers	ers own	MD			
	Registr		MAY 0 8 20	07 Lineur 1	1. Boards	9			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Jean G. Blum 11:32 A M 3 2007 May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death Examiner Stella Maris Hospice Timonium, MD Baltimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 X F Director 215 18 5020 83 Aug 28, 1923 Maryland Usual Residence of Decedent 10c. City. Town or Location 10a, State 10b. Count 10d. Inside City Limits or 28a-f show Examiner must be notified at 1 ☐ Yes 2√☐ No Director Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a 405 Kilree Rd. Unit 104 21093 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Ite 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: White ģ 3 ☑ Widowed 4 ☐ Divorced Completed Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry MAY 3, 2007 11:32 Baltimore, Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) N/A Accounting Manager Petroleum Fuel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Dewey Miller Abbie May Townsend ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 405 Kilree Rd. Unit 104, Timonium, MD 21093 ce of Disposition (Name of Date 20c. Location - City or Town, State Rita E. Miller (sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) Gardens of Faith Cemetery 20a. Method of Disposition 23a. Part 1. Enter the isease, or complications that cause in the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, limenating Carle (Find isease or condition resulting in death) 20a. Part 1. Enter the isease, or complications that cause in the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, limenating Carle (Find isease or condition) 20a. Part 1. Enter the isease, or complications that cause in the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, limenating Carle (Find isease or condition) 20a. Part 2. Name and Address of Facility 21a. Name and Address of Facility 22b. Name and Address of Facility 2a. Part 3. Enter the isease, or complications that cause in the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, limenating Carle (Find isease or condition) 2b. Part 3. Enter the isease, or complications that cause in the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, limenating Carle (Find isease or condition) 2b. Part 3. Enter the isease, or complications that cause in the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, limenating Carle (Find isease) 2c. Name and Address of Facility 2c. Name and A Department of Baltimore, MD 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley Inc. IO Padonia Rd. Timonium, MD 21093 Approximate Interval Between Onset and Death **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami and Due to (or as a consequence of) P.O. Box 68760. Physician/Medical the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 💢 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2X No 1∐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 ☐ Yes 2 ▼ No 1 🔲 Inpatient ٩ 2 ER/Outpatient 3□ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Records, JEAN Division or Vital I or Attending Physician: after death. Director: After this certifica To the Hospital o within 24 hours aff To the Funeral D

State Registrar

31. Date filed (Month, Day, Year) MAY 08

DR. TARIQ MAHMOOD

29b. Signature and title oncertifier

29a. Certifier

one)

(Check only



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year)

	•	For State Registrar	State of Ma	iryiand /	-	rtment of H tificate of L		ientai Hy	'gien Reg. N		
Dharieis		1. Decedent's Name (First, Middle, Las	t)					2. Date of De	eath	2007	3. Time of Death
Physicia /Medic		C:	Laire M.	Bayles	ss			May	2,	2007 Year	11:54 PM
Examin	er	4a. Facility Name (If not institution, give	*			4b. City, Town, or	Location of Death		40	c. County of Death	1
5		Montgomery Hospid				Rockvi				Montgome	
Funeral Director		5. Social Security Number 6. Social Security Number 077-01-9699	☐M 2127 F	e (In yrs. last bi	Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da October	ay, Year	r) Cou	place (State or Foreign intry) York
/land		10a. State 10b. County		10c. City, Tov	vn or Loc	ation					10d. Inside City Limits
Man a-f sh fied	ţċ	Maryland Montgome	ry	Potom	ac						1 ☐ Yes 2 XX No
th the	Director	10e. Street and Number				10f. Zip Code			10g. C	itizen of What Cou	intry?
23a ust b	ra [9609 Kentsdale Di	rive			2	0854		Un:	ited Stat	tes
er dez	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		13. V	vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Span, Mexican, Puerto	ecify Yes or No Rican, etc.))-	14. Race - Ameri Black, White	
urs a	2	1 ☐ Never Married 2 ☐ Married 3 🕅 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates:	lo	1	□Yes 2█No	Specify:			0. "	White
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withir ene. than	ш	Elementary/Secondary (0-12)	College (1-4or 5	, I		nse Analv			For	lamal Cam	
filed Hygi sther	ပ္ထ	17. Father's Name (First, Middle, Last)			/CI CI	ise Analy	18. Mother's Name	(First, Middle		deral Gov	rernment
ld be lental ked o	To Be	William G. Heuern	nann				Gertrud			•	
shou and N s mar		19a. Informant's Name/Relationship (7	ype. Print)	19	b. Mailing	g Address (Street a	and Number or Rur				ip Code)
and 2 salth a 127 ls		Valerie K. Wolf /	Daughter	9	609	Kentsdal	e Drive,	Potoma	c, M	faryland	20854
of He of He f Item		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Domoval from State	20h Place	of Dienos	sition (Name of natory or other place Nationa		Date		ocation - City or T	
nit. Pag artment ortant: I Injury o		4 Donation 5 Other (Specify 21. Signature of Funeral Service Licen.)	Ariin	emer	Name and Address	o of Facility			ington,	
Dep Imp		Ing Later Dan	met MC	01305	Rot 300	ert A. Pum West Mont	phrey Funer gomery Aven	al Home/ ue, Rock	Rock Ville	ville, Inc e, Maryland	20850-2805
		23a. Part1. 5 ter the disease, or comp shock, or heart failure. List only	lications that caused one cause on each lin	the death. Do e.	not ente	r the mode of dying	g, such as cardiac o	or respiratory a	rrest,		Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Metast			Cancer					Onset una Beauti
Examiner			Due to (or as a	a consequence	of):						
1900	e.	Sequentially list conditions, if any, leading to immediate	b. — Due to (or as a	a consequence	of):						
cuted	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events	c								
cate be executed physician and the burial-transit		resulting in death) Last	Due to (or as a	consequence	of):						
ate b hysic the bu	ledical		d								
ertific ling p	Med	IF FEMALE:									
eath certifi attending for use as	ian	in the past 12 months?	23c. If yes, outcome p 1 ☐ Live birth 4 ☐ Pregnant at	2 🗌 Fetal deat		Ectopic pregnancy			- 1	23d. Date of deliver Month	very Day Year
The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	1 ☐ Yes 2 🖾 No 9 ☐ Unknown	9□Unknown	ume or death	2□	Other (specify)					•
that bed by deta	y P	Part II. Other significant conditions co	ontributing to death bu	t not resulting	in the un	derlying cause give	n in Part I.	23e. Did t	obacco	use contribute to	the cause of death?
w requires that been signed to should be deta	Completed by	Chronic Obstructi	ve Pulmona	ary Dis	ease	<u> </u>		1 🗆	Yes 2	2 □ No 3 🎇 Pro	bably 4 Unknown
aw re s bee	olete							24a. Was	an	24b. Were aut	opsy findings available
: The law cate has I	E							auto perfo 1⊟ Yes	psy ormed? 2 ☑ N	prior to co	ompletion of cause of 2 No
sician: The certificate rector, pag	Bec	25. Was case referred to medical examiner?					26. Place of Death			O ILITES	2 140
hysic this ce	2	1 ☐ Yes 2M No		nt 2□ER/O	utpatient	3 □ DOA Othe	r: 4 ☐ Nursing Ho	me 5□Resi	dence	6 NOther (Speci	(fy) Hospice
ing P		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day		Time of Injury	28c. Injury Work		28d. Describe	how inju	ury occurred	
death ctor: / the	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of inju	ny - At home for	arm etra		res 2□No	Oof Location /	Chuncha	- d M	- C N
ttal or A rs after ral Dire	Certification:	4 Homicide determined	building, etc	. (Specify)				City or To	wn, Stat	,	
	Medical	29a. Certifier 1 ★ Certifying Phyone) 2 ■ Medical Example 1 ★ Certifying Phyone 1 ★ Cer	vsician: To the best of iner: On the basis of and manner sta	examination a	e, death nd/or inv	occurred at the tim estigation, in my op	ne, date and place, pinion, death occurr	and due to the red at the time,	cause(s	s) and manner as and place, and due	stated. to the cause(s)
To t Withi To t	Σ	29b. Signature and title of certifier Aprillia M	Dille	Amino - A	מה	29c. License	number 58032		Comp.	ate signed (Month,	
5	}	30. Name and address of person who o							//(Ly 3,2	WT
12		Cynthia M. Willia	ms, D.O.	6001 M			l Road, R	ockvil]			
Stat	_	31. Date filed (Month, Day, Year)								-	
Registra		MAY 0 8 2	007 Alexander	r's Signature	S. S. S. S. S. S. S. S. S. S. S. S. S. S	10 - G-0-					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Registrar

DHMH 17 Rev 1/2001

State

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			1 For State	State of Marylar	nd / Depa	artment		Mental Hygie	ene 007	14734
	Physic	ian	Registrar 1. Decedent's Name (First, Middle, Last)		Oei	lincate	OI Dealii	2. Date of Death	Day Year	3. Time of Death
0	/Medi Examir	cal	Virginia Bryant 4a. Facility Name (If not institution, give s Keswick Nursing Home	treet and number)		4b. City, To	wn, or Location of Deal	1	4c. County of Dec	7:40 P M
	Funeral Director			M 2X F 7. Age (In yrs. 86	last birthday) Yrs.	If Under 1 Months 0	Year If Under 24 Hrs Days Hours Min.		(ear) 9. Bi	irthplace (State or Foreign Country) MD
	he Maryland 28a-f show ctiffed at	ector	Usual Residence of Decedent 10a. State MD 10b. County	10c. Ci	ty, Town or Lo	Balti	·			10d. Inside City Limits 1 XYes 2 No
	h with 1	D E	10e. Street and Number 4803 Tamarind Road A	Mpt. 106		10f. Zip C	21209	100	g. Citizen of What C USA	Country?
036	be filed within 72 hours after death with the Maryland hat Hygiene. Id other then "natural", or Items 23a or 28a-f show event, I'm Madical Exarting must be notified at	by Funeral Director		2. Was Decedent Ever in U Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Deceder f Yes, specify	t of Hispanic Origin? (S Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Wh	
21215-0036	within 72 ho ene. then *natur he Madical	Completed by	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	16a. Deced (Give life. L	dent's Usual (kind of work of OO NOT use	Occupation done during most of wo retired)	rking	6b. Kind of Business	s/Industry
N	Hygi ther ont, I	Be Co	9 17. Father's Name (First, Middle, Last)		1	dome	18. Mother's Na	me (First, Middle, Ma	home uiden Sumame)	
Maryland	should be ind Mental marked o	To B		n Gray				Resa Bour	me	
Mar	s 1 and 2 should i Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type Michael A. Bryant / So	, ,			treet and Number or Ri ard Street; B			
re,	ges 1 an t of Heal if item 2 or other		20a. Method of Disposition	20b. I	Place of Disposemetery, cren	sition (Name	of		c. Location - City o	
Baltimore,	Pa Int:		1 X Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval itom State	ng Memori	ial Park	05/10		ndallstown,	Maryland
Ball	permit. Pag Depertment Important: i sny injury o		21. Signature of Funeral Service License	00000	63	Name and A	Address of Facility Wy Imor Street;	lie Funeral	Home, P.A.	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	ation that caused the deal e cause on each line.	h. Do not ente	or the mode of	f dying, such as cardia	or respiratory arrest		Approximate Interval Between Onset and Death Ameritas
	eath certificate be executed ettending physicien and for use as the burial-transit	Ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consecuence to (or as a consecuence)						10 7 60015
P.O. Box 68	The law requires that the death certifica te has been signed by the ettending ph bage 2 should be detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of c 9 Unknown	Ideath 3	Ectopic pregr Other (speci			23d. Date of de Month	olivery Day Year
ds, P	signed by det	þ	Part II. Other significant conditions conf	ributing to death but not res	ulting in the un	derlying caus	e given in Part I.			o the cause of death?
		Completed						24a. Was an autopsy performer	24b. Were a	utopsy findings available completion of cause of
Vita	ilcian: T certificet rector, pa	Be	25. Was case referred to medical examiner?	spital:			Other	th Check only one		
ō	g Phys er this eral di	n: To	27. Manner of Death	28a. Date of Injury	28b. Time of		Other: 4 Wursing H Injury at Work?	ome 5 Residence		ecify)
sion	ending sath. or: Aft he fun	atlo	1 atural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	М	Work? 1 ☐ Yes 2 ☐ No			
Division of Vital	To the Hospital or Attending Physician: within 24 hours eller death within 24 hourseller death To the Funersi Director: After this certified completely filled in by the funeral director,	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	v)			28f. Location (Stree City or Town, S	State)	
	e Hosp 24 hou e Fune etely fil	Medical	29a. Certifier 1 Certifying Physic (Check only one) 1 Medical Examination	cian: To the best of my kno er: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at t estigation, in	he time, date and place my opinion, death occu	, and due to the caus rred at the time, date	se(s) and manner as and place, and due	s stated. e to the cause(s)
	To th To th comp	Me	29b. Signature and title of certifier	Λ		29c. Li	cense number		Date signed (Mont	
	/		▶7 Fahelle Tas	- greger	つり		13657	Vla	ly 7,20	07
	ъ		30. Name and address of person who con TISABEWE The	REGOR, 700	W-41	o th st	REET, BA			
	Sta Registr		31. Date filed (Month, Day, Year) MAY 0.8 2007	32. Registrar's Signa	ture					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Diana Miller Capaletti 2007 May 4, 6:10 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Stella Maris Timonium Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Dec. 5, 1926 5. Social Security Number 7. Age (In vrs. last birthday 6. Sex Birthplace (State or Foreign Country) **Funeral** York 216-20-2413 1 □ M 2 🔽 F 80 New Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show "natural", or Items 23a or 28a-f shovidical Examiner must be notified at Director 1 ☐ Yes 2 ☐ Nio Baltimore MD Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3117 Garden Avenue 21234 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2K Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify by Specify: White 3 Widowed 4 Divorced Year or Dates: er than "natur, the Medical E Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Black and Decker and Mental Hygiene. Executive Secretary 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Health and Mental Arthur Miller Olga Griebstein 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2::
Department of Health at Important: If item 27 Is any injury or other trauonce. Nick Capaletti-spouse 3117 Garden Avenue-Parkville, Maryland 21234 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) EVANS FUNERAL CHAPEL May 6,2007 Forest Hill,MD AND CREMATION SER Relair 21. Signature of Funeral Service Licensee 22. Name and Address of Facility EVANS FUNERAL CHAPEL 8
AND CREMATION SERVICES 8800 Harford Road LIVI Parkville,MD 21234 adde maral Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ABDOMINAL CANCER resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed sician and resulting in death) Last Due to (or as a consequence of): Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4⊡Pregnant at time of death 5 ☐ Other (specify) ☐ Yes 2 No 9□Unknown 9 Unknown been signed the should be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🙀 Unknown Completed been : 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has t autopsy perform within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag 1∐ Yes 2**X** No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Hospital: 1 ☐ Yes 2 X No မ 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA 0 HOSPICE 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Leading Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 0 8 Registrar

DHMH 17 Rev 1/2001

CAPALETT

DIANA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician 2:15 p Janet S. Carr Apr 29, 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner Baltimore 1504 Moreland Avenue If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral Hours Months Days 1 □ M 2 □ F Virginia Director Jan 23, 1932 140-24-4608 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 Kes 2 No Director Baltimore N/A Marvland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A 21216 1504 Moreland Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ X If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 □ Never Married 2 □ Married r than "natural", or the Medical Examir Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ 🙀o ģ Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **Baltimore City Schools Crossing Guard** d 2 should be filed who and Mental Hygiel 17. Father's Name (First, Middle, Last) or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event Be Rosie Smith McKinley Smith ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1504 Moreland Avenue Baltimore, Maryland 21216 Jacqueline Coplin Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Purial 2 ☐ Cremation 3 Removal from State Accomac, Virginia 05/07/07 4 Donation 5 Dother (Specify) Mt. Nebo Cemetery 21. Signatur of Funeral Service Lice 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** eon resulting in death) /Medical Due to (or as a nsequence of) Examiner Sequentially list conditions, if an leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine be executed P.O. Box 68760,√ as the burial-tran and Due to (or as a consequence of) ed by the attending physician detached for use as the buria Physician/Medical the death certificate IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 3 ☐ Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9☐Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 Tyes 2/**Z**| No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1∐ Yes Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 21 No Besidence 6 □Other (Specify) ပ 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a Date of Injury 27. Magner of Death 28b Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After 1 (Month, Day Year) 1 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No il or Attend after death. | Director: / 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical

within 24 hours a To the Funeral L Hospitai completely filled the

h

29b. Signature and title of certifier

30 Name and address of

State Registrar

00 31. Date filed (Month, Day,

egistrar's Signature

who completed cause of death (Item 23a) (Type, Print)

P

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month OMPTON **Physician** OSEPIT 450 M 05 05 07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Medical Center Annapoli's Anne Arundel Anne 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Director 246-64-657 North Capolina Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits 1. Yes 2 No Anne Director Arnold Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 702 Jupiter Hills USA 21012 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ★ Yes 2 No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced ear or Dates: 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Engineer Electronics 2 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Violet Josephine Davis Compton, Sr. Connor James ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) wife Hills Patricia Compton 702 Jupiter Arnold MD 21012 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4⊠Donation 5 ☐ Other (Specify) Andromy Gifts Registry May 6,2007 Hanover, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Anatomy Gofts Registry 7522 Connelley Drive suite P. Hanover, MD 21676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Date to for as a consequence of Physician/Medical Examiner use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the burial IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cate has by page 2 s autopsy perform To the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ဥ funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Sulcide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of pertifier 29c. License number ho completed cause of death (Item 23a) (Type, Print) EFENSE HIGHWAY, ANNAUSMOLIYO 30. Name and address of person y ins ATT

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Keiko Campbell May 2007 2:05 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Arch Place #321 Montgomery Darnestown If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year)
June 25, 1930 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🗓 F 248-02-0377 Director 76 Japan Usual Residence of Decedent 3a or 28a-f show at be notified at 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Director Maryland Montgomery Darnestown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20878 1 Arch Place #321 United States 23a "natural", or items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 📆 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: Asian ğ 3 Widowed 4 Divorced Completed Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natu any injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 1 and 2 should be filed wi Health and Mental Hygier em 27 Is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Not Available Not Available ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arch Place, #321, Darnestown, Maryland 20878 William J. Campbell /Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 20a. Method of Disposition 20c. Location - City or Town, State May 5, 1 ☐ Burial 2 ☐ Cremation 3 □Removal from State Montgomery Crematorium, Inc. Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2007 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Rockville, Inc. angelette Barn M01305 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part1. Eiver the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Colon Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): burial-transit death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Exami Due to (or as a consequence of): P.O. Box 68760 physician Physician/Medical as the t IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ó in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown cate has been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy performed? 1□ Yes 2 🔀 No 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🖫 Residence 6 Other (Specify) Hospital: မ 1 ☐ Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Certification: or Attending 1 🕅 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check enly one) and manner stated. the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) eara ourer MD D16619 May 4, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9940 Franklin Square Drive, Baltimore, Maryland 21236 Corazon Vergara-Soares, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAY 08

			1- For State of Maryland / Dep Registrar Ce	artment of Health and Martificate of Death	ental Hygie Reg.	2007	14739
F	Physicia	an	1. Decedent's Name (First, Middle, Last)			Day Year	3. Time of Death
Г	/Medic	al	MARIE SENNOTT COSGROVE 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	May 1, 2	007 4c. County of Deat	5:30P ^M
	Examin	er	Edenwald	Towson		Baltimore	
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	Director		213-05-6878	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	lovember 25,	,1911 Mar	yland
	aryland show		10a. State 10b. County 10c. City, Town or Li	ocation			10d. Inside City Limits
	e Mar	ctor	Maryland Baltimore Towson				1 ☐ Yes 2 ☐ No
	with th	Directo	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Co	untry?
	Jeath Triust	Funeral	800 Southerly Road 11. Marital Status 12. Was Decedent Ever in U.S. 13.	21286 Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto F	cify Yes or No-	USA 14. Race - Ame	rican Indian,
٥	or Iter		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X X No	If Yes, specify Cuban, Mexican, Puerto F 1□ Yes XIX No Specify:	Rican, etc.)	Black, White	
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Mary	2 t a 7			Sussex Road Towson			up code)
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Ĕ	Pages ment of I ant: If its ury or o		A Donation 5 Other (Specify) Parkwood	Cemetery 5/4/			Maryland
Baltimore,	pernit. Pages Department of Important: If it any njury or o		21/3 nature of Funeral Annice Licensee 2	2. Name and Address of Facility Mitc			
		-	23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	6500 York R		re, Marylar	Approximate
L.	Pnysician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	- 1 1 - 6.	1.		Interval Between Onset and Death
	/Medical		resulting in death) a Due to (or a > 10 isequence of):	a remy for	me		0 44
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<u>ra</u>		e C	25. Was case referred to medical	26. Place of Death	1 ☐ Yes 20		2 □ No
I VII	Physician: r this certific ral director,	To B	examiner? 1 Yes 2 No	Other		6 ☐Other (Spec	city)
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UNISION	death ctor: / the f	ertification:	2 Accident Investigation 3 Suicide 6 Could not be 280 Place of Injury. At home form et	M 1 Yes 2 No	8f Location (Street	and Number or Ru	ral Route Number
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	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	edical C	29a. Certifier Certifying Physician: To the best of my knowledge, deat (Check only Medical Examiner: On the basis of examination and/or in	h occurred at the time, date and place, a	nd due to the cause	e(s) and manner as	stated.
	the H hin 24 the F mplete	Medi	one) and manner stated. 29b. Signature and title of certifier	29c. License number			
	1 × 10	-	250. Signification and title of sociation	N 4-97	69	Date signed (Month	A-7
	in		30. Name and address of person who completed cause of death (Item 23d) (Type,	Print)	11 4	0 1	1712-
	D		anvelius D. Albreraci	N 5/6 NRV	the Pd	BNA.	hol 4228
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	Sta Registr		31. Date filed (Month, Day, Year) 52. Degistrar's Signature	soul !	V		

			1 - For State Registrar	State of Marylar		tment of H ficate of		Mental Hy	/giene2 Reg. No.	007	1474	
	Physic /Medi		1. Decedent's Name (First, Middle, La. Dr. Frank Anth	nony DeLaura				2. Date of D Month MAY	eath Day	2007	3. Time of Death 200 PM	
	Examinum Funeral Director	ner	4a. Facility Name (If not institution, given SAINT AGNES 5. Social Security Number 6. S 127-07-7099	HOSPITAL	. last birthday)		If Under 24 Hrs. Hours Min.	8. Date of Bi	rth	Cour	olace (State or Foreigr ontry) 'York	
	Maryland -1 ehow	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Baltimon		ity, Town or Loca Catonsvi			0 0 0 1 1	1, 15		Od. Inside City Limits 1 ☐ Yes 2 ☑ No	
	ath with the 23a or 28a and be noti	Funeral Director	10e. Street and Number 719 Maiden Choice	Lane, HR 101		10f. Zip Code 21	228		USA	n of What Cour	ntry?	
036	be filed within 72 hours after death with the Maryland la Hygiene. d other than "naturel", or iteme 23a or 28a-1 show event, it a Medical Exercit or must be notified at	þ	11. Marital Status 1 □ Never Married 2 ☆ Marned 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ™Yes 2 □ No II Yes, Give Year or Dates:		s Decedent of Hes, specify Cubi	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or N to Rican, etc.)		Race - Americ Black, White, pecify:		
1215-0	within 72 ho iene. • than "natu ire Medicel	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+) 5+	16a. Deceder (Give kir life. DO Physic		pation during most of wor d)	rking		of Business/Inc		
Maryland 21215-0036	ould be filed Mental Hygi arked other atic event,	ag	17. Father's Name (First, Middle, Last) Anthony DeLaura				18. Mother's Nar	ne (First, Middle retta La	, Maiden Su		eu	
	t 1 and 2 shi Health and tem 27 le m		19a. Informant's Name/Relationship (Alma DeLaura / W 20a. Method of Disposition	ife 20b. F	719 Ma	iden Ch	1		sville		land 21228	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or items 23s or 28s-1 show any injury or other traumatic event, the Medical Examinar mant be notified at once.		1 Burial 2 M Cremation 3 4 Donation 5 Other (Specification of Funeral Service License)) Bay		ematory ame and Addre	5/14 ss of Facility Hu		uneral	l Home,		
68760, 4	Coate be executed / Medical Examiner and physicien and phy	edical Examiner	23a. Part1. Enter the disease, or compshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	th. Do not enter to ATS quence of): ANE quence ol):	He mode of dyin	101	e or respiratory a	IROLE,	Ŧ	Approximate Interval Between Onset and Death U.S. DITY	
Р.О. Бох 68	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnation 1 Live birth 2 Feta 4 Pregnant at time of degree Unknown	aldeath 3 □Ec	topic pregnancy ther <i>(specify)</i>			23d		,	
	requires that been signed b hould be deta	eted by Pr	Part II. Other significant conditions on HYPE 12-TE	entributing to death but not res	ulting in the unde	rlying cause giv	en in Part I.		23e. Did tobacco use contribute to the cause of death? 1			
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JIVISION OF	il or Attending Physicien: The I after death. I Director: After this certificate ha d in by the funeral director, page	Certification; To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year) 28a. Place of Injury - At houiding, etc. (Specifications)	28b. Time of Injury		er: 4 🗆 Nursing H	ome 5 Resi 28d. Describe	dence 6 how injury oc	ccurred	r) I Route Number,	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	Medical C	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam	rsician: To the best of my kno iner: On the basis of examina and manner stated.	owledge, death oc tion and/or invest	29c. License	pinion, death occui	rred at the time,	date and pla	d manner as stace, and due to	the cause(s)	
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DH	Sta Registr MH 17 Rev 1/20	ar	31. Date filed (Month, Day, Year) MAY 0 8 20	32. Seristrar's Signa	ture							
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Physician /Medical Examiner

death with the Maryland f show iral", or items 23a or 28a-f shov Examiner must be notified at 28a-f "natural", or items 23a Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
unt: if item 27 is marked other than "natural", or iten
ury or other traumatic event, the Medical Examinear. permit. Pages 1 Department of H Important: If ite any Injury or ot

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

The law requires that the death certificate be executed attending physician and for use as the burial-trar Division or Vital Records, P.O. Box 68760. ed by the a page 2 should be the Hospital or Attending Physician: funeral director, this Director: within 24 hours a To the Funeral L completely

4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 610 Hoddsmill Road Woodbine Carroll 5. Social Security Number 7. Age (In yrs. last birthday) if Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 □ M 2 🔀 F 03/10/1932 216-28-6946 75 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10a State 10h. County 10d. Inside City Limits 1 ☐ Yes 2 X No Director Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 United States 5214 Wilkens Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2X No Specify: White Specify ģ 3 Widowed 4 □ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rose Eder Kleophus Haiden ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Geraldine Kubin (Daughter) 8016 Kavanagh Road, Baltimore, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 05/08/2007 Middle River, Maryland Holly Hill Cemetery 4 □ Donation 5 □ Other (Specify) 22 Name and Address of Facility Hubbard Funeral Home, 21. Signature of Funeral Service Licenses Made T-4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the diseas per lications that shock, or heart failure. List only one cause on ications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did toba co use contribute to the cause of death? þ 2 □ No 3 ☐ Probably 4 ☐ Unknown Completed 4b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy 1 Yes 2[25. Was case referred to medical examiner? Be 26. Place of Death (Check q Other: 4 Nursing Home Hospital: 3□ DOA 1 Yes 1 Inpatient 2 ER/Outpatient Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 ☑ Natural 2 ☐ Accident 5 Pending investigation injury 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of ter Street (18544111546) State MAY 0 8 2007 Registrar

6:30

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-	4		For Amend a State Registrar	#26 p er	Phy G867	ary / 08	Cei	tificate	of D	eath			2007	S. Cong	742
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100	/Medic		Rebecca		Duval1						April	27			58 p M
	Examin	er	4a. Facility Name (If not in 14909 01d Columnia 149		,			Burtons		Location of Death			c. County of Dea ontgomery	ith	
-	Funeval		5. Social Security Number			je (In yrs. I	ast birthday)	If Under 1		If Under 24 Hrs.	8. Date of Bir		-	thplace (State	or Foreign
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	rland ow at			. County		10c. City	, Town or Lo	cation						10d. Inside (City Limits
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	r dea ems	Funeral	11. Marital Status		12. Was Decedent Armed Forces?	•	S. 13.	Was Deceder f Yes, specify	nt of His Cuban	panic Origin? (Sp n, Mexican, Puert	pecify Yes or No Rican, etc.))~	14. Race - Ame Black, Whi		
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. It health and marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married : 3☐ Widowed 4 ☐ I		1 □ Yes 2 🔀 If Yes, Give Year or Dates:	No		1□Yes 2万		Specify:			Specify: Whi		
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Ž	should ind Men marke umatic	ဥ	19a. Informant's Name/F	Relationshin (Tvi	ne Print)		19h Mailir	n Address /S		nd Number or Ru	ral Route Numb	er City	or Town State	Zin Code)	
Ma	nd 2 s Ith an 27 ls trau	ļ	Claudia Krouse		·					Burtonsv				zip code)	
ē,	other	ŀ	20a. Method of Disposition			20b. P	1	sition (Name natory or othe			Date		ocation - City or	Town, State	
9	Pages lent of nt: If i		1 Bunal 2 □ 6re		emoval from State		n Cemet		er piace	1	1, 2007	Burt	tonsville,	Marylan	d
Baltimore,	permit. Pages 1 and 2 s Department of Health an Important: If item 27 Is i any injury or other traui	İ	21. Signature of Funeral		e 1 (e //.			. Name and /			S1- S-		D 1 1	1 MD 20	707
					cations that cause	d the death				Home 7601			Road Laur		
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P.0	that t ed by detac	문	Part II. Other significant	conditions con	tributing to death b	ut not resu	Ilting in the u	nderlying caus	se giver	n in Part I.	23e. Did t	obacco	use contribute t	o the cause of	death?
g.	uires signe	d by									10	Yes 2	2	robably 4	Unknown
00	w require been sign	lete									24a. Was	an	24h Were a	utopsy findings	available
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ta		Be C	25. Was case referred to	medical						26. Place of Dea	1 Yes	2 PN	o 1 □ Yes		
_ >	rysicl lis cer direc	ToB	examiner? 1 ☐ Yes 2 ☐ No	Н	ospital: 1 🔲 Inpati	ent 2 🔲	ER/Outpatier	t 3□ DOA	Other	,,	ome 5⊡ he si		6 XXther (Spe	Daug Decify) House	ghter'
0 U	Attending Physiclan: r death. ector: After this certifics by the funeral director, p		27. Manner of Death 1 Natural 5 [Pending	28a. Date of Inju (Month, Da	ıry ı <i>y Year</i>)	28b. Time of Injury	28c	Injury Work?	at ?	28d. Describe			- HOU	⇒€
Sio	Attendii death. ctor: A y the fu	atic	2 ☐ Accident	investigation Could not be				М		es 2 □ No					
Division or	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 € 4 Homicide	determined	28e. Place of in building, e	ury - At ho tc. <i>(Specif</i> y	me, farm, str ')	eet, factory, o	office		28f. Location (City or To	Street a wn, Stai	nd Number or R te)	ural Route Nu	mber,
	pital urs a eral [ပ္	29a. Certifier 1	Contifue Dhus	ician: To the best	of my leno	uladaa daat	a courted at	Ale o Alimo		and due to the				
	Hos 24 ho Fun etely	Medical	(Check only 2 one)	Medical Examir	ner: On the basis of and manner st	of examinat	tion and/or in	vestigation, in	my op	e, date and place inion, death occu	rred at the time,	date ar	s) and manner a nd place, and du	s stated. e to the cause	(s)
	omple	Me	29b. Signature and title o	of certifier	\sim	r		29c. L	icense	number		29d. Da	ate signed (Mon	th, Day, Year)	
	->-0		Herene	re Wrol	Marsk	i wi	,	D	00	6461:	5	41	30/0	7	
	κ	1	30. Name and address o	f person who co	mpleted cause of	leath (Item	23a) (Type,	Print)				/ '			
	Sta	to	Genevie 31. Date filed (Month, Da	ve Wr	oblews 32 Registr	ki h	11) 13	53 P	100	card D	r. Ro	CK	ville v	ud 20	0850
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DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death May Month **Physician** 06ay 2007 Andrew Defassio 12:00 ам /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Stella Maris Timonium 8. Date of Birth (Month, Day, Year)
May 30, 1914 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1X M 2□ F 190-01-4552 92 Pennsylvania May Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Md. Baltimore Timonium 1 ☐ Yes 2 X No Director 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 21093 USA 2314 Wuthering Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💆 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Michael Defassio Margaret Hudson ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2314 Wuthering Rd. Timonium, Md. 21093 Mrs. Ruth Defassio/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ XBurial 2 ☐ Cremation 3 | Removal from State Dulaney Valley Mem. 5-8-07 Timonium, Md. 4 Donation 5 Dother (Specify) 22. Name and Address of Facility RUCK Towson, Funeral H 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a. ASPIRATION PNEUMONIA /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine use as the burial-trar Due to (or as a consequence of) Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4□Pregnant at time of death 5 ☐ Other (specify) 9□ Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE ပ 1 ☐ Yes 2X No 2 ER/Outpatient 3□ DOA Division or 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending Injury 1 Yes 2 No investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

9

ANDREW DEFASSIO

			1 - For State Registrar	State of M	aryland		artmen rtificate			and M		iene	07	14745
	Physicial	22	Decedent's Name (First, Middle, I	.ast)							2. Date of Deat Month	h Day	Year	3. Time of Death
	Physici /Medio		Menestia		elliP:	izzi	,				May 3,	2007		10:00 P ^M
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			Manor Care Ru: 5. Social Security Number 6.		e (In yrs. la	et hirthday)	If Under	Tows	on If Under :	24 Hrs	8. Date of Birth		Balti	
ı	Funeral Director		173-50-3872	1□M 2XF	102	Vre	Months	Days	Hours	Min.	(Month, Day, March 1			lace (State or Foreign try)
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	arylar show	_	10a. State 10b. County		10c. City,	Town or Lo	cation						1	Od. Inside City Limits
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03	ral', c	l by	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2	XNo	Specify:			Specify	· Wł	nite
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	and 2 ealth a n 27 Is		Anne Toroni/Dau	ghter		200	Char	nuth	Road	Ti	monium,	MD 210	93	
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Ë	Pages ment of tent: If it		*4 □ Donation 5 □ Other (Spec	city)	Ceme	Monic Monic etery	ca		N	lay 9	9, 2007	Pao1	i, PA	
Baltimore,	permit. Pages Department of Importent: If i any injury or once.		2 Ign III a Funeral Service Lic	Bryan W.C	larv	Le	Mame and emmon : Name and emmon	Fune	eral i	Home	of Dula	ney Va	11ey,	Inc.
0,	/Medical Examiner but and but are the burial-transit	Examiner	23a. Part1. Enfer the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in the cause of the caus	y one cause of each lin	a conseque	nticence of):	ar the mode	e or aying	, such as o	cardiac o	r respiratory arre	st,		Approximate Interval Between Onset and Death
.O. Box 68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Who 9 □ Unknown	d	2 Fetal d	leath 3	Ectopic pre					23d. Dat Mor	e of delive	ry Day Year
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uc	ding I	Certification:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injui (Month, Day	Year) 2	8b. Time of Injury	28 M	Work Work	at ? es 2 □ N		l8d. Describe hov	v injury occurr	ed	
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	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	edical C	29a. Certifier 1 Certifying F (Check only one) 1 Medicel Exe	thysicien: To the best of miner: On the basis of and manner sta	examinatio	edge, death n and/or inv	occurred a restigation,	t the time	e, date and inion, death	place, a	nd due to the cau	ise(s) and ma e and place, a	nner as sta and due to	ated. the cause(s)
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ì	\) lz	Arc	M	R	17	100	544	124	1 5	5-4-	07	
	N		30. Name and address of person who	completed cause of de 206. Tim	eath (Item 2	(3a) (Type, 1	Print)				menici			e93
::	Sta		31. Date filed (Month, Day, Year)	32. Registra	ar's Signatur	re P					-			
	Registr	ar	MAY 0 8 2	2007	J. J.	40	Me							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year 3:35 p M **Doris Foote** May 1, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. Cify, Town, or Location of Death 4c. County of Death Examiner Genesis Eldercare-Randallstown Randallstown Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Days Hours Months 1 M 2 F Director 217-16-3811 Usual Residence of Decedent Jan 8, 1924 Maryland with the Maryland r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 TXYes 2 □ No Director Baltimore N/A Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ral", or items 23a or Examiner must be U.S.A. 3025 Harlem Avenue 21216 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married "natural", or altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No δ Specify. Black 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker other Department of Health and Mental Hyg Important: If Item 27 is marked other any Injury or other traumatic event, i 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ella Rogers Ransom Sutton မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23 Bannock Court Randallstown, Maryland 21133 Rose Foote Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Dopattion 5 □ Other (Specify) 05/08/07 Owings Mills, Md. Garrison Forest Veterans Cemetery 21. Signature of Funeral Sovice Licenses 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 po not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final (ment) **Physician** Dunnad disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner A circlent. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) law requires that the death certificate be executed the burial-transi HTN Due to (or as a consequence of): P.O. Box 68760, attending physiclan for use as the buria IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hiknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No page 2 autopsy performed certificate 2 No or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 🗀 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 ☐ Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No after death 2 Accident the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a To the Funeral I completely filled Hospital 🛮 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

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2600 LIBERTY

AZTIMORE

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21215

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

Division or Vital Records, P.O. Box 68760. To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

Registrar

Medical

29b. Signature and title of certifier

Sabapally

29c. License number

D 30641

2018/09 Back River Neck Local Balhmer Maryland 21221

29d. Date signed (Month, Day, Year)

May 4, 2007

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🗎 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Vear **Physician** MAY ANNE FINK 4 2007 5:10 P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** HOSPICE OF BALTIMORE GILCHRIST CTR BALTIMORE If Under 1 Year | If Under 24 I 8. Date of Birth (Month, Day Birthplace (State or Foreign Country) **Funeral** Days Min Months Hours 1 □ M 2 🙀 F 94 07/14/1912 CANADA Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 □Yes 2□No Director MD BALTIMORE BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 7 SLADE AVENUE #621 21208 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No WHITE Maryland 21215-0036 "natural", or Specify If Yes, Give Year or Dates: ģ Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) the <u>TEACHER</u> **EDUCATION** ייים ב should be file mportant: If them 27 is marked other y injury or other traum 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ZALMON ENCHIN LIBBY ROSEN ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 100 HARBOR VIEW DRIVE #2102 -MARILYN DICKMAN / DAUGHTER BALTIMORE, MD 21230 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remoyal from State permit. Page Department o Important: If any injury or once, 4 □ Donation 5 □ Other (Specify) BETH JACOB CONG. 05/06/2007 FINKSBURG, MD 21. Sign 22. Name and Address of Facility SOL LEVINSON & BROS., INC. of Funeral Service Li 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 hth. Enter the disease, or complications has caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest stock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** year /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed as the burial-tra Due to (or as a consequence of). Completed by Physician/Medical IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 XNo Month Year been signed by the s should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 2 No certificate or Attending Physician; funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 ☐ Homicide within 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated.

Division or Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year 0 8

29b. Signature and title of certifier

MD 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

			1 - For Amend #1, perME	State of Maryla , G867, 5/31/07	nd / Depa	artment of I	Health an <i>Death</i>	d Mental Hy	giene Reg. No. 0 (7 14	749
	Physic	ian	Decedent's Name (First, Middle, La	st)				2. Date of De Month		3. Time	of Death
	/Mec		ANTHONY Anthony Gu			FREEM	AN-	MAY	5 200		5 A M
	Exami		48. Facility Name (If not institution, giv	e street and number)		4b. City, Town,	or Location of D	eath	4c. County of	of Death) A
1			7707 WISCONSIN AV	ENUE #304		BETHESE				GOMERY	
	Funeral		5. Social Security Number 6. S	ex /. Age (in yr	s. last birthday) 72 Yrs.	If Under 1 Year Months Days		Hrs. 8. Date of Bir Min. (Month, Da	th ly, Year)	Birthplace (State Country)	e or Foreign
	Director		143-26-0309 Usual Residence of Decedent	X	Z Yrs.			12/06/1		N]
	aryland •how		10a. State 10b. County	10c. (City, Town or Lo	cation				10d. Inside	City Limits
	r 28a-f ehow	to	MD MONT	GOMERY	BETHESD	Α					es 2v No
	with the Maryland a or 28a-f ehow	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of W		^
	after death with or Itema 23a or	O E	7625 EDENWOOD COU	RT		20817	,		U.S.A.	,	
	ter death trema 23	ner	11. Marital Status	12. Was Decedent Ever in	U.S. 13. V	Vas Decedent of I	Hispanic Origin	(Specify Yes or No	- 14. Race	- American Indian,	
9	or its		1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 ☑ Yes 2 ☐ No	+	Yes, specify Cub		uerto Rican, etc.)	Black	, White, etc.	
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ä	be fi	Be	17. Father's Name (First, Middle, Last) GERALD					Name (First, Middle,	Maiden Surname)	
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Maryland	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Imporant: If item 27 is marked other than "natur eny hjury or other traumatic event, tra Madical ORCE.	1 8	19a. Informant's Name/Relationship (MARIA ELISA FREEMA					Rural Route Numbe			
	1 and fealt em 2 ther		20a. Method of Disposition		Place of Dispos	EDENWOOD	COURT	- BETHESD	A, MD 208		
Baltimore,	ages at of l		1 X Burial 2 ☐ Cremation 3 X	Removal from State	cemetery, crem	atory or other pla	ce)	Date	20c. Location - C	ity or Town, State	
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Ba	permit. Departe Import eny inj pnce.		21. Signature of Funeral Service Licer	500	22.	Name and Addre	ess of Facility S	OL LEVINS	ON & BROS	S. INC.	
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	/Medical Examiner	δ ¹	rosating in doutry	Due to (or as a conse				7			
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V	and all-trar	xan	that initiated events resulting in death) Last	c. Due to (or as a conse	nuence of):						
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9 x	The law requires that the death certifical has been signed by the attending phagge 2 should be detached for use as I	Physician/Me	IF FEMALE:	23c. If yes, outcome of pregr	ancy						
Вох	atten for u	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fet	al death 3 □l	Ectopic pregnancy	1		23d. Date Month		Year
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<u>α</u>	that the de led by the a detached t	유	Part II. Other significant conditions of	ontributing to death but not re	sulting in the un	darking cause au	ran in Part I	23e Did to	haasa usa santah	ute to the cause of	i donth?
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Division	al or Attend s after death il Director: A id in by the f	Certification:	4 ☐ Homicide determined	28e. Place of Injury - At the building, etc. (Special	nome, farm, stree fy)	et, factory, office		28f. Location (S City or Tow	treet and Number n, State)	or Rural Route Nu	mber,
7	To the Hospital or Att. within 24 hours after de To the Funeral Direct completely filled in by ti		29a. Certifier 1 Certifying Phy	reinian. Tarta harring	eviled :						
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	F ≱ F 8		Patricia To	msko Ma	y, mil	H D	519/1	c f	29d. Date signed (i	Onlin, Day, Year)	Z
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			1 - For Amend #5, perFH, G	367°, 5/14/07°11	Cer	tificate of	Death		eg. No.		: /50
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	/Medic		Daniel 4a. Facility Name (If not institution, give stre	eet and number)	Gc	ines J:	r Location of Death	may	4c. County of	Death .	3.72
	xamin	er	Simi Hospital Dt			Biltin	more City		40. County o	Dealli	
	ineral		5. Social Security Number 6. Sex 1 219-18-6172 1 XM	7. Age (In yrs		Months Days	If Under 24 H/s. Hours Min.	8. Date of Birth (Month, Day 03 01	Year) 5	9. Birthpl Count	ace (State or Foreign try) M.D.
	ector		Usual Residence of Decedent	82	110.			03 01	25		עויו
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3	Dec III	Funerai		Was Decedent Ever in tarmed Forces?	J.S. 13. V	Vas Decedent of H Yes, specify Cuba	lispanic Origin? (Spean, Mexican, Puerto F	cify Yes or No- lican, etc.)	14. Race Black	- America White, e	
g 60	E#	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1X Yes 2 □ No If Yes, Give Year or Dates:		□Yes 2 □No	Specify:			Bla	ack
1215-003 within 72 hours	lisal E	Completed	15. Decedent's Educat (Specify only highest grade of	ion ompleted)	16a. Deced	ent's Usual Occup	ation	a	16b. Kind of Bus	ness/Ind	ustry
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a d a d a si	9 6	6 B	Daniel Gaines				Mary Be	nnerma	ın		
and and	raumatic		19a. Informant's Name/Relationship (Type,				and Number or Rural			Lestern	
Health	other		Diane M. Gaines—1 20a. Method of Disposition	20b.	Place of Dispos	ition (Name of	Country		20c. Location - C		
			1 Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	iovai from State		atory or other place n Fores	t Vet 5/	10/07	Owing	s Mi	ills, Md
Salti Salti Permit.	eny injury or once.	1	7. Signature of Funeral Service Licensee	n)		Name and Addre					
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Division of Vital Records, P.O. Box 687 ior Attending Physician: The law requires that the death certificate after death.	for use as the	by Physician/Medic	230. Was decedent pregnant	If yes, outcome of pregn 1□Live birth 2□Feta					23d. Date	of deliver	у
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Division To the Hospital or Attentiviting 4 within 24 hours after death	completely filled in by the funeral director, page 2	Medicai (29a. Certifier (Check only one) 1 X Certifying Physicial Examiner:	an: To the best of my kno On the basis of examina and manner stated.	owledge, death ation and/or inve	occurred at the tinestigation, in my o	ne, date and place, ar pinion, death occurre	nd due to the ca	ause(s) and mannate and place, and	er as sta d due to	ited. the cause(s)
To the Tro the	E oo	Σ	29b. Signature and title of certifier Auraly Mills	+ m.D		29c. Licenso	number 0 56 388	29	9d. Date signed (Lin	2007
3	11		30. Name and address of person the comp	leted cause of death (Iter	п 23а) (Туре, Р	rint)	Has	1.0	BIH	ima	,
	Stat		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	- All -	110 70	1	1	1111)	
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ORIGINAL

1 - For State Registrar

		•	1 - State Registrar					Cer	tifica	te of l	Death			R	eg. No.	200	7 11	75
	1,5		1. Decedent's Name (First, Mid	dle, Last)									2. Date Mon	of Dea	th Day	Year	3. Time of	Death
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	Examir		4a. Facility Name (If not instituti			mber)			4b. City	, Town, or	Location	of Death				ounty of Deat		
	LAGIIII		10209 Taniger	Lane	3				Co	lumbi	а				Н	oward		
±{	Funeral		5. Social Security Number	6. Sex		7. Age ('In yrs. las	t birthday)	If Und	er 1 Year	If Under		8. Date	of Birth	1	9. Birt	hplace (State o	r Foreign
ы	Director		004-20-4863	004-20-4863 1 M 2 XF 80					Months	Days	Hours	Min.	APR	1 2	12 1927 Country) Maine			
•	4		Usual Residence of Decedent										232.10				Line	
	/lanc		10a. State 10b. County 10c. City, Town or Local														10d. Inside Ci	ty Limits
	Man f sh	tor	MD Howa									1 □Yes	2 X No					
	the 28a notif	rec	10e. Street and Number	Lu			COTO	mbia	10f. Zip Code						0g. Citize	en of What Co	untry?	
	yith yard	Ō	10209 Taniger	Land	3				2	1044						USA		
	eath	Funeral Director	11. Marital Status		12. Was Dec	edent Ev	er in U.S.	13. V			ispanic Or	igin? (Spe	ecify Yes	or No-	14	4. Race - Ame	rican Indian,	
	Item Iner	'n.	1 □ Never Married 2 X Ma		Armed Fo 1 ☐ Yes	orces?			f Yes, sp	edent of H ecify Cuba	an, Mexica	in, Puerto	Rican, e	tc.)		Black, White	e, etc.	
36	rs af	by F	3 ☐ Widowed 4 ☐ Divorce		If Yes, Gi	ve			1 🗆 Yes	2 N 0	Specify	:			5	Specify:	White	
8	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at	ed	15. Decede	ent's Edu	cation			16a. Deced	lent's Us	ual Occup	ation				16b. Kind	d of Business/		
21215-0036	in 72 "na fedic	olet	(Specify only high	est grade	completed)	4 5 5		(Give life. L	kind of w	ork done o use retired	during mos f)	st of worki	ing					
7	with ene. thar	Completed	Elementary/Secondary (0-12)		College (1-40r 5+)		Teacl							Pub	lic Ed	ucation	ı
0	filed Hyg ther	Ö	17. Father's Name (First, Middl	e, Last)							18. Moth	er's Name	e (First, I	Middle,				
au	d be ental	Be c	Theodore M	cDow	e11					- 1	Bet	ulah	F]	lemi	ng			
$\overline{\geq}$	hould Me Mark	To	19a, Informant's Name/Relation					19b. Mailin	a Addre	ss (Street						Town, State, 2	7in Code)	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		Donald M. Gra			d										yland		
a)	of Health a item 27 is other trau		20a, Method of Disposition				20b. Plac	ce of Dispo	sition (N	ame of	- 1	-	Date		20c. Loca	ation - City or	Town, State	
و	ages or or o		1 ☐ Bunal 2 🗽 Cremation		emoval from	State	cen	netery, cren	natory o	other plac		E //.	1200	,				
₽	tmer tant tant ijury		4 □ Donation 5 □ Other					ro Cre								imore,		
Baltimore,	Depar Depar Impor any Ir		21. Signature of Funeral Service	e License Ven	H. Wi	llia	ms	22	Cre	matic	n So	ciety	of	Mar	ylan	d, Inc	•	
		_	A	w	Ma	~			299	Fred	eric	k Roa	ad, I	Balt	1mor	e, MD	21228	
П			23a. Part1. Enter the disease, shock, or heart failure. Li	or compli st only or								s cardiac o	or respira	atory arr	est,		Approximat Interval Bet	ween
2	Physician		Immediete Cause (Final disease or condition				Pn	eur	noi	red							Onset and I	Jean
je.	/Medical		resulting in death)		Due to	(or as a	conseque	nce of):										
н	Examiner			1.			De	eur hoe of): by d hoe of): err hoe of):	rail	w								
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	uted d ansit	Ē	cause. Enter Underlying Cause (Disease or injury that initiated events	1			De	enu	ent	id								
Ć,	exec n an ial-tr	Examiner	resulting in death) Last		Due to	(or as a	conseque	nce of):	//		e							
92	e be sicia	cal		L.			ar	rly	tus	wa	1							
68760,	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Medical		122														
×	cert nding use		IF FEMALE: 23b. Was decedent pregnant	2	3c. If yes, ou				_						23	3d. Date of del	livery	
Bo	atte for	cia	in the past 12 months?				☐ Fetal dome of dea		JEctopic] Other (pregnancy specify)	/					Month		Year
P.O.	The law requires that the death ate has been signed by the atter bage 2 should be detached for u	Physician	1 ☐ Yes 2 ☐ XNo 9 ☐ Unknown		9□Unkr	nown												_
σ.	that ed by deta	무	Part II. Other significant cond	tions cor	ntributing to c	leath but	not resulti	ng in the ur	nderlying	cause giv	en in Part	1.	23€	. Did to	bacco us	e contribute to	the cause of c	leath?
ds	sign d be	d by	1	221	erte	use	m							1 🗆 Y	es 2	No 3□P	robably 4 □l	Unknown
Ö	requ	etec		01									-					
ě	e law	п											24a	autop	sy	prior to death?	utopsy findings completion of c	available ause of
<u></u>	. The page	Completed											10	perfor Yes	2 XNo	1 ☐ Yes	2 □ No	
/Its	cian; ertific	Be	25. Was case referred to medic examiner?	-						la.		e of Death	h (Check	only or	7e)			
_	hysia his c	2	1 ☐ Yes 2 X No	1	lospital: 1 🗆	Inpatient		R/Outpatien			4 LI N	ursing Ho	me 5	Resid	ence 6	□Other (Spe	cify)	
Division or Vital Records,	ng P fter t nera		27. Manner of Death 1 XNatural 5 ☐ Pend	ling	28a. Date (Mor	of Injury oth, Day		8b. Time of Injury	f	28c. Injur Wor	y at k?		28d. Des	scribe h	ow injury	occurred		
9	endli ath. or: A he fu	aţic	2 ☐ Accident inves	tigation					М	1 🗆	Yes 2]No						
Š	r Atte er de recte by t	titio	3 Suicide 6 Coul 4 Homicide dete	mined	28e. Place build	e of injury ling, etc.	- At home (Specify)	e, farm, str	eet, facto	ory, office					treet and n, State)	Number or R	ural Route Nun	nber,
$\overline{\Box}$	s afte	Certification:																
	bour hour uner															and manner as		6)
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	one)	ar Examil		ner state		ii oild/Ul III	resugali	ori, ili iliy C	γριτιοπ, de	an occur	icu at th	ume, (aate and	piace, aliq qui	e to the cause(2/
	To th To th	ž	29b. Signature and title of genti	ier	110				2	9c. Licens	e number	7		2	29d. Date	signed (Mont	h, Day, Year)	
	1		1354	-	110					D50	1876	J		1	rlay	1410	2007	1
ž	0		30. Name and address of person	n who co	mpleted cau	se of dea	ıth (Item 2	3g) (Type.	Print).	0	/ 1					11	110 -	1000
1	U		30. Name and address of personal 200 Address of personal 200 Address of personal 31. Date filed (Month, Day, Yea	do	MD	500	05	19911	al	Bel	L La	ME	, (la	rus	ull '	IR MIN	020
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	Regist		MAY 0	3 200	32.1	9450	RIP	1	Page 1									
			311111	y														

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

			For	State of Maryland	d / Depa		alth and N	•	giene	77 mg 4 1 mg 2000 p
			State Registrar		Cer	tificate of De	eath		Reg. No.	0/ 14/52
	Physici	an	1. Decedent's Name (First, Middle, L	ast)	GK	ROVES		2. Date of Dea Month	Day Y	ar 144 20 M
	/Medic Examin		4a. Facility Name (If not institution, gr	ve street and number)	1	4b. City, Town, or Lo	ocation of Death	MAY	4c. County of	0 1 14 20 M
	LAdimin	Ci	BALTIMORE VI	7 MediCALL	enter	PAG	1	Re	^	14
	Funeral Director		5. Social Security Number 6. 218–56–7993	Sex 7. Age (<i>In yrs. la</i> 1 X M 2 □ F 56			f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	1950	Birthplace (State or Foreign Country) WV
	DC 3		Usual Residence of Decedent 10a. State 10b. County	10c City	, Town or Lo	cation				10d. Inside City Limits
	(sho	jo	MD Anne Ar		ure1	outron.				1 ☐ Yes 2 XNo
,	r 28a-	Funeral Director	10e. Street and Number	under Ind	urer_	10f. Zip Code			10g. Citizen of Wha	at Country?
3	238 o	al D	311 Old Line Ave	nue		20707			WSA	
	tems	ner	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	5. 13. V	Vas Decedent of Hispa Yes, specify Cuban, I	anic Origin? (Sp Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Black,	American Indian, White, etc.
36	rs affe	by Fi	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 □ No If Yes, Give Year or Dates: 70-7	2 1	☐ Yes 2 No 5	Specify:		Specify:	White
21215-0036	within /2 hours atter death with the Maryland ane. Then "neturel", or Items 23e or 28e-f show he Neutsal Examina must be multited at	ted	15. Decedent's i	Education	16a. Deced	ent's Usual Occupation	on .		16b. Kind of Busin	
2	e	Completed	(Specify only highest g Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done duri OO NOT use retired)	ing most of worl	king		
വ ∙	filed wi Hygien other th		12		Busin	ess Owner			Carpet (Cleaning
Maryland	should be the should be the should be the should be the should be the should be the should be the should b	To Be	17. Father's Name (First, Middle, Last Ira Oliver	Groves			Bonnie	Lee	Maiden Sumame) Legg	
Mary	N 40 20 00		19a. Informant's Name/Relationship William Frederic	(Type, Print) Brother		g Address (Street and Kingsfiel			•	
	Health tem 27 other tr		20a. Method of Disposition	20b. Pla	ace of Dispos	sition (Name of	lu Laue,	Date Date	20c. Location - Ci	
e e	Pages nent of I nnt: If It iry or o		1 ☐ Burial 2 🛣 Cremation 3 '4 ☐ Donation 5 ☐ Other (Spec	Hemoval from State	•	matory or other place) matory, In	oc 5/4/	2007	Baltimor	co MD
	permit. Pages Department of Importent: If It eny injury or one		21. Signature of Funeral Service Lice	en H. Williams	22	Name and Address of	of Facility	of Mar	vland Ir	e, Fib
<u> </u>	8258		15 TH	ille		Cremation 299 Freder	ick Roa	d, Balt	imore, M	21228
, F	hysician		23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition	nplications that caused the death. y one cause on each line	Do not ente	er the mode of dying, s - Shu c	such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death
E	/Medical Examiner		resulting in death)	Due to (or as a consequence	ence of):	00.1.	116	1.1	homA	
		er	Sequentially list conditions, if any, leading to immediate	b. Diff 45 C	ence of):	ege Ce	460	- Awt	TIOMIT	
	d d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C						
ó	te be executed ysician and e burial-transit		resulting in death) Last	Due to (or as a conseque	ence of):					
	2 2 9	dical		d						
89 ×	ding p	/Med	IF FEMALE:	23c. If yes, outcome of pregnan	ncv				224 2	4 4-1
Вох	es that the death certifica igned by the attending ph be detached for use as tf	by Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Fetal of dead of the state of dead of the state of the	death 3 [Ectopic pregnancy Other (specify)			23d. Date of Month	
0	t me c by the achec	hysi	9 Unknown	9□ Unknown						
s, D	The law requires that the ste has been signed by th page 2 should be detache	by Р	Part II. Other significant conditions	contributing to death but not resul	lting in the ur	nderlying cause given i	in Part I.			ute to the cause of death?
ord	w require been sig should t	ted						1 U Y	es 2 LN 3	☐ Probably 4 ☐Unknown
Records,	has b	Completed						24a. Was autop	sv pric	re autopsy findings available or to completion of cause of other.
<u>a</u>	ysicient: The list contilicate he director, page	e Co	25. Was case referred to medical					1 ☐ Yes	2□N6 1□	Yes 2□ No
Vital	rnysicien: this certifica ral director, j	0	examiner?	Hospital: 1 Impatient 2 E	R/Outpatien	Othor		th <i>(Check only o</i> ome 5 □ Besid	ence 6 □Other	(Specify)
ָה ה	두 등 등	T :u	27. Manner of Death 1 ■ Natural 5 □ Pending		28b. Time of Injury	28c. Injury at Work?			ow injury occurred	(4,2-1.1))
<u> </u>	Attending ir death. ector: After by the fune	catic	2 ☐ Accident investigati	on		M 1 ☐ Yes	s 2 🗆 No			
Division of	To the Hospitel of Attent within 24 hours after death To the Funerel Director: completely filled in by the	Certification;	3 Suicide 6 Could not 4 Homicide determine		me, farm, stre	eet, factory, office		28f. Location (S City or Tow		or Rural Route Number,
	to the Rospitel or within 24 hours afte To the Funerel Dir completely filled in I		29a. Certifier 1 Certifying F	hysicien: To the best of my know	vledge, death	occurred at the time,	date and place,	and due to the o	ause(s) and mann	er as stated.
;	Io the Ho within 24 f To the Fu completely	fedical	(Check only 2 Medicel Exe	eminer: On the basis of examination and manner stated.	on and/or inv	estigation, in my opini	ion, death occur	red at the time, o	date and place, and	due to the cause(s)
,	within To the Comple	Σ	29b. Signature and title of certifier	di MD		29c. License no	umber 46		29d. Date signed (/	Month, Day, Year)
1 h	1		Unish Ha	noor	22a\ /T	7 /8.	504		PUTY >	0001
10	7		A mish GANO	completed cause of death (Item	∠3a) (Type, I	10N 67	REGNE	5410	t Baltin	10KF MD21201
.	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ure Speed			100	-11-1	/
100	Registr	ar	MAY 0 8 200	7 Martin A.	SAN BAL	4.0				

1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** GZEGORY GUSTUN 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Month, Day, Yea Aug. 24, MATETLAND MEDICAL CENTER UNIVEZSITY OF 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 **∑**M 2 ☐ F 213-66-6485 52 Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

em 27 Is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County MD Baltimore Director Monkton 10e. Street and Number 10f. Zip Code "natural", or Items 23a or edical Examiner must be r 4017 B Old York Road 21111 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) traumatic event, the Medical Elementary/Secondary (0-12) College (1-4or 5+) Salesman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Francis Guston, Jr. Helen Nowakowski ပ 19a. Informant's Name/Relationship (Type. Print) Theresa M. Peet, M.D. (wife) mit. Pages 1 and 2 partment of Health a cortant; If Item 27 Is 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Highview Mem. Grdns. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee **Physician** Brain Traymatic

/Medical Examiner

physician and s the burial-trans as use jo ed by the a detached f signed to be detail certificate has been si rector, page 2 should I

Division or Vital Records, P.O. Box 68760,

State

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4017 B Old York Road, Monkton, MD. 20c. Location - City or Town, State 05/09/2007 Fallston, MD. 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Thims Due to (or as a consequence of): Vehicle M. MEDICAL E Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only onle) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ို 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 100 PM 5 ☐ Pending investigation 1 Natural 1 TYes Vehicle 07 2 Accident rash 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Neiry non S. M. 11 P. C. Godon Roll Phoenix, M. 1 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Roadwai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier M.D. 17384 05 02 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE, MD STEVENS, M.D. 51. 22 GREENE 31. Date filed (Month, Pay, Year) 4 AV 0 8 2007 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Day

1^{Year)}1954

OZ

Year

NIA

4c. County of Death

10g, Citizen of What Country?

14. Race - American Indian,

Black, White, etc.

Specify: White

Pharmaceutical

16b. Kind of Business/Industry

USA

17:33 PM

Birthplace (State or Foreign Country)

Maryland

10d. Inside City Limits

1 ☐Yes 2√No

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician \mathbf{P}^{M} MAY 2007 4:45 Allison Green Donald /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE GREATER BALTIMORE MEDICAL CENTER TOWSON 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 1 9. Birthplace (State or Foreign 6. Sex 1**XX**M 2□ F 5. Social Security Number **Funeral** Dec.22, Maryland Director 213-26-3609 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location death with the Maryland 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Towson Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21286 802 Mockingbird Lane Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 ▼Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: White ۾ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Westinghouse Draftsman 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Creighton Mae Roxie Green Clyde ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Reisterstown, Maryland 21136 307 Academy Ave. LeDonne Niece F. Diana 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Service Corp. 5-7-2007 Towson Maryland 4 □ Donapon 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 Ant 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) FAILURE HOURS RESPIRATORY Physician /Medical Due to (or as a consequence of): ONE DAY Examiner PNEUMONA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of): Examiner ONE DA requires that the death certificate be executed the burial-transi SERSIS and Due to (or as a consequence of): physician Physician/Medical for use as 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Month in the past 12 months? 5 ☐ Other (specify) 1 Yes 2 No ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 2 Onknown OPD CHF, METASTATIC LUNG CANCER 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 1□ Yes certificate To the Hospital or Atter ding Physician: within 24 hours a er death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 Tes 2 No 1_mpatient 28c. Injury at Work? 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: (Month, Day Year) Injury Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

Registrar

D16189

who completed cause of death (Item 23a) (Type, Print)

N. KARKARMO PA- 6565 N. Challost, 4615 Towson

NO 21204

porge N. Karkar mo

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

EORGE

MAY 08

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene

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į	1	-1)	5.

		•	For State Registrar	State of Marylan	· ·		e of Dea			Reg. No.	007	14755
1	Physicia		1. Decedent's Name (First, Middle, La Ruth Estelle			-			2. Date of Dea 1a y 6 ,		Year	3. Time of Death 7:45 P M
•	/Medic Examin		4a. Facility Name (If not institution, giv Stella Maris	re street and number)			Town, or Locati	ion of Death			nty of Death	
	Funeral Director		5. Social Security Number 213-68-2616	Sex 1□M 2XF 7. Age (In yrs. 57	last birthday) Yrs.	If Under Months	1 Year If Un Days Hou	ider 24 Hrs. Irs Min.	B. Date of Birth Month, Day June	25,1949	9. Birthi Mars	place (State or Foreign office) Tand
	Maryland -f show ied at	tor	Usual Residence of Decedent 10a. State 10b. County MD Balt	imore 10c. Cit	y, Town or Lo	cation arkv	ille		-			10d. Inside City Limits 1 ☐ Yes ※ No
	h with the 3a or 28a st be notif	Funeral Director	10e. Street and Number 2910 Andorra (Court Apt. F		10f. Zip	Code 21234			10g. Citizen o		intry?
036	ges 1 and 2 should be filed within 72 hours after death with the Maryland not Health and Mental Hygiene. If flem 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	ρ	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ № ivorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ Mo if Yes, Give Year or Dates:		Was Dece If Yes, spe 1 □ Yes	dent of Hispanic cify Cuban, Me 2 No Spe		ify Yes or No- ican, etc.)	Spec	Race - Ameri Black, White, cify: W	
P·m. 21215-0036	I within 72 ho jene. r than "natui the Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	(Give	dent's Usua kind of wo DO NOT u nema]	al Occupation rk done during i se retired) Ker	most of workin	g	16b. Kind of		ndustry
:45	uld be filed Mental Hyg Irked other Itic event,	To Be C	17. Father's Name (First, Middle, Last William T. Sv				Ма	other's Name ry Ell	en Te	resa	Lund	
	d 2 sh th and 7 is m traum		19a. Informant's Name/Relationship Robert Hindle	Jr-son	1313	3 Ca	nberra	Drive	-Balt	imore	,Mar	
Y 6, 2007 Baltimore.	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Removal from State	Place of Disponentery, crest S FUNES WATTON S	sition (Name matery or of AL CHA FR. Bel	ne of other place) PFL AND Air	May 1	1 , 2007	20c. Location Correst H	lill,Mar	ryland
MAY 6 ■ Balt	permit. Depart Import any Inj		21. Signature of Funeral Service Lice	nsee Juddu	EN AJ	2. Name ar VANS 1 ND CR	nd Address of F FUNERAL EMATION	acility CHAPET SERVIC	8800 Pa ES	Harfo rkvill	rd Ro e,MD	ad 21234
24	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	pplications that caused the deat one cause on each line.						rest,		Approximate Interval Between Onset and Death
٦	/Medical Examiner		resulting in death)	Due to (or as a conseq				DIOME				
×	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or in lury that initiated events resulting in death) Last	Due to (or as a conseq	uence of):							
68760.	rificate be executed g physician and as the burial-transit	ledical Ex	resulting in death) Last	Due to (or as a conseq	uence of):							
Box	The law requires that the death certificate be executed the has been signed by the attending physician and hage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☎ No 9 □ Unknown	23c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of co 9 ☐ Unknown	ıl death 3 🛭	⊒Ectopic p ⊒Other (sµ					Date of deliv Month	very Day Year
E ds. P.O	es tl igne igne	by	Part II. Other significant conditions	contributing to death but not res	ulting in the u	nderlying o	ause given in P	art I.				the cause of death?
HINDLE I Records.		Completed							24a. Was autop perfo 1∐ Yes	an 24 osy rmed? 2X No	b. Were autoprior to condeath?	opsy findings available ompletion of cause of 2 ☐ No
RUTH 1	ding Physician: The h. After this certificate hr funeral director, page	To Be (25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	nt 3 □ D0	Other:	Place of Death			Other (Spec	ify) HOSPICE
U	Attending Physician: r death. ector: Affer this certific by the funeral director,		27. Manner of Death 1 X Natural 5 □ Pending 2 □ Accident investigation		28b. Time o	f M	28c. Injury at Work? 1 ☐ Yes	2	8d. Describe h			.,,
Division	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the i	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		ome, farm, sti	reet, factor	y, office	2	Bf. Location (5 City or Tow		mber or Rur	ral Route Number,
	To the Hospital or A within 24 hours after To the Funeral Direction Completely filled in b	Medical	29a. Certifier (Check only one) (Check only one)	hysician: To the best of my knominer: On the basis of examination and manner stated.	owledge, deat ation and/or in	h occurred ovestigation	at the time, da	te and place, a , death occurre	nd due to the d at the time,	cause(s) and date and plac	manner as a	stated. to the cause(s)
	To the vithin To the company	M	29b. Signature and title of certifier)		29	c. License numb	72(-		29d. Date sig	ned (Month)	, Day, Year)
	7		30. Name and address of person who DR. TARIQ MAHMOO). TIM	ONIUM,	MD 210	93		
	Sta		31. Date filed (Month, Day, Year)	32 Registrar's Signa						-		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND TTEM#20b, c. perFH G867, 5/11/07, WS
State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Mac 9:59 AM 2007 ta /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Parylar.

| 6. Sey | 17 1/2 2 F Baltimore land Medical Center N/A niversitu Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Director 214-62-5377 Jun 3, 1956 Marvland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Xes 2 No Director N/A **Baltimore** Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3927 Norfolk Avenue 21216 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: I flem 27 is marked other than "natural", or Ite any lijury or other traumatic event, the Medical Examine. 1 XNever Married 2 ☐ Married 2 No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify <u>ک</u> Specify Black 3 Widowed 4 Divorced 1974 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) BCCC Student-In-Training 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William A. Hall Sr. Lueiser Douresseau 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4644 Hawksbury Road Pikesville, Maryland 21208 Craig Hall 20b. Place of Disposition (Name of Appletory, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑Burial 2 □ Cremation 3 □ Removal from State Palto Mil. 05/10/07 4 Denation 5 Other (Specify) Garrison Forest Veterans Cemetery signature of Funeral Service License 22. Name and Address of Facility Estep Brothers Funeral Service, P. A.

1300 Eutaw Place Baltimore, Md 21217

Shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) ancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine be executed that initiated events resulting in death) Last and burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 5 ☐ Other (specify) 4□Pregnant at time of death cate has been signed by the a page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 robably 4 Unknown 1 ☐ Yes Completed 24a. Was an autopsy performed?
1□ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Umpatient 2 ER/Outpatient 3 DOA ို After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No death. 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Ecclifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) reak(Greene 31. Date filed Wonth, Day, Year) Registrar's Signature State 2007 0 8 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

atricia Handier		State of Maryland / Department of For State Certificate of Maryland / Department of State of State of State of State of Maryland / Department of State of S		_	g. No.	01 1910
Physicia	_	Registrar 1. Decedent's Name (First, Middle,Last)		2. Date of Death	1	3. Time of Death
l Exami		Patricia Ann Handleman		Month May 3, 200		1616 hrs
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dea	
		1 Spinners Ct. Apt B	Randalistown		Baltimore Co	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs Months Days Hours Min		h (MM/DD/YYYY) 9. E Fore	eignBaltimore.
Director		212-42-7799 1 M 2 F 63 Y	rs.	Feb.12	,1944	eignBaltimore, Country)Maryland
any	}	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc	ation			10d. Inside City Limits
		Maryland Baltimore County Randalls				1 Yes 2 No
Maryland 28a-f show d at once	흉	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Co	ountry?
th the Maryland 23a or 28a-f sho notified at once	Director	1 Spinners Court Apt.B	21133	11	nited Stat	-es
with t is 23a		11. Marital Status 12. Was Decedent Ever in U.S. 13. V	Vas Decedent of Hispanic Origin? (Sp	ecify Yes or No-	14. Race - Am	erican Indian, Black,
feath r iten	Funeral	1 Never Married 2 Married Armed Forces?	Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.	
after o	by F	3 Widowed 4 Divorced If Yes, Give Yeer or Dates:	Yes 2 No specify:		Specify: V	White
5-0036 led within 72 hours after Hygiene. other than "natural", the Medical Examiner	eted t	during	ent's Usual Occupation (Give kind of working life. DO NOT use reti		16b. Kind of Busines	s/Industry
36 n 72 l nau ", ical F	je j	Elementary/Secondary (0-12) College (1-4 or 5+)				_
withi	Comple	10 n/a 17. Father's Name (First, Middle, Last)	Home Maker 18. Mother's Name	(First Middle M	Own I	lome
al Hy	Be C	Abraham Handleman	Margaret			
212 wild be Ment mark	To E		ing Address (Street and Number or I	Rural Route Num	ber, City or Town, Sta	ate, Zip Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Marhal Hygiene. Important: I fleat 2; is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once		Mr. Bruce Carlton Ultez (Son) 1 Sp	inners Court Apt	.B Rand	dallstown,	MD. 21133
re, l l and Heal l item			osition (Name of cemetery,	Date	20c. Location - City	or Town, State
Pages ent of int: I			neral Chapel 5-	6-01	Forest H	Maryland
altil mit. pertm ports ury o		21. Signature of Funeral Service Ligensee / 22	. Name and Address of Facility		1.0	
a 55 5 5 5		John A. gar, br. 2	eaceful Alternati 325 York Road Ti	ves Fund monium,	eral&Crema Maryland	tion Ctr.P.A 21093
'nysician Medical		23a/Part I/Enter the disease, or complications that caused the death. Do not ente failure. List only one cause on each line.	r the mode of dying, such as cardiac o	or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
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P.O. Box 68760, that the death certificate be executed need by the attending physician and detached for use as the burial - transit	Medical	UNPENDED AMENDED				
760, cate b physic he bur		IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deliv	ery
Box 687 death certific the attending p	Physician/	past 12 months?	Fetal death 3 Ectopic pregn.	ancy	Month	Day Year
OX leath of e atter for us	/sic	1 Yes 2 No 9 V Unknown	Other (Specify)			
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, P.O. res that the signed by be detach	d by	Hemorrhagic gastritis		1 Yes	2 No 3 P	robably 4 🗸 Unknown
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eco ne law te has ge 2 s	μď				rmed? death	?
tal Recian: The certificate ector, page	Ç	25. Was case referred to medical	26.Place of Death (Check			
Vita hysicia this ce	o B	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	ent 3 DOA Other Nursi	ng Home 5	Residence 6 🗸 Ot	her: Scene
Division of Vital Records, tal or Attending Physician: The law requir at a fair chain at Director: After this certificate has been s led in by the funeral director, page 2 should t	n: ⊤	27. Manner of Death 28a. Date of Injury (Month Day Year) 28b. Time of Month Day Year)		28d. Describe h	how injury occurred	
ion ttendi leath tor:	atio	Natural 5 Pending 2 Accident Investigation	1 Yes 2 No			
ivis or Au after of Direc	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, st	treet, factory, office building, etc.	28f. Location (S or Town, S		Rural Route Number, City
D spital hours neral fille	Š	4 Homicide determined (Specify) 29a. Certifier 4 Continue Physician To the heat of my knowledge death oc		<u> </u>		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	ical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death oc one) 2 Medical Examiner: On the basis of examination and/or investi				
To t To t	Medical	and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (i	
	-	Our S	O.C.M.E.		May 4, 2007	
£)		30. Name and address of person who completed cause of death (Item 23a)				
<i>A</i>			Street, Baltimore, MD 2120	1		
		31. Date filed (Month, Day, Year) 32. Registrar's Signature				

Registrar

ichael Hittle, Sr.	1.	- For State	State	of Maryland	Deparl <i>Certi</i>	tment of ficate of	Health and Death	d Menta		Reg. No.	2.0	07 147
Physician		egistrar . Decedent's Nam	e (First, Middle,Last)					2. Date of De	ath Day	Year	3. Time of Death 1350 hrs
ledical Examin	er	Michael I	Hittle, S	r					May 1, 20	007	c. County of Deat	
	4		if not institution, give Pulaski Street	e street and number)		4	b. City, Town, or Baltimore	Location of L				
Funeral Director		5. Social Security I 218-70-5.	2/5	x 7. Ag	e (In yrs. las 48		If Under 1 Year Months Day				, 1958 C	rthplace (State or ign ountry) MD
ny		Usual Residence o	of Decedent 10b. County		10c. City, T	own or Location	on					10d. Inside City Limit
id fe wa	اي	MD	N/A		Balti	lmore						1 X Yes 2 N
death with the Maryland or items 23a or 28a-f show any must be notified at once.	മെ	10e. Street and Nu 549 Lucio					10f. Zip Code 21229			10g. Cir	tizen of What Co	untry?
with the ns 23a o		11. Marital Status		12. Was Decedent		13. Wa	s Decedent of Hi	spanic Origir n, Mexican, F	n? (Specify Yes or No Puerto Rican, etc.)		14. Race - Ame White, etc.	erican Indian, Black,
er death	Funeral	Never Marr Widowed	ried 2 X Married		X No		Yes 2 X No				_{Specify:} whi	te
ours afte	ig by	15. Decedent's E	Education (Specify o	nly highest grade co		16a. Deceden during m	t's Usual Occupa ost of working life	ation (Give ki e. DO NOT u	nd of work done se retired)	16b.	Kind of Business	3/Industry
5-0036 led within 72 hours after Hygiene. other than "natural"; th. Medical Examine	Completed	Elementary/Sec	ondary (0-12)	College (1-4 or		Welder					achine	
5-00 led wit Hygien I other			e (First, Middle, Last						Name (First, Middle			
121 d be fi tental narked		Kenneth .	Jerome Hi	ttle [vpe. Print]		19b. Mailing	Address (Stre	et and Numb	Marlynn F per or Rural Route N	UMber,	IIan City or Town, Sta	ite, Zip Code)
and 2 shoul cealth and N tem 27 is r traumatic	_		Hittle, J			3203	Lily Av	enue A	pt B Balt	imo		227
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	Ì		X Cremation 3	Removal from S	20b. P	rematory or ot St Arun	ition (Name of cher place) Idel Cre	_{emetery,} natory	Date 5-7-2007			Maryland
Baltim permit. Pa Departmen Important injury or		Donation 21. Signature of	5 Other Speq#) Jumeral Service Lice	nsee /								of Lansdo
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Physician i al				plications that cause each line. Head injur	ries		•					Between Onset a Death
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	er	Sequentially list of if any, leading to	immediate	Due to (or as a con	sequence of	F):						
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50, te be en nysician burial	Medical	IF FEMALE:		#23a,27,2			/3, 11/16	/U/_TT_			23d. Date of deliv	
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cords law requi has been	Completed								p	utopsy erforme es 2	d? deat	
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sion attendi death ctor:	atio	1 Natural 2 Acciden	5 Pending t Investig	Allen LINU D/ I	/2007	Fnd 1:5	eet, factory, office			on (Stre	et and Number o	or Rural Route Number,
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Division of Vital Records, P.O. Box virtual Accords, P.O. Box within 24 hours after death to the Fineral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for u.			B.	ician: To the best oner:On the basis of e	f my knowlog	dge, death occ and/or investig	curred at the time	, date and pl nion, death o	ace, and due to the courred at the time,	cause(s date and	s) and manner as d place, and due	stated. to the cause(s)
To the vithin To the comp	Medical	29b. Signature	and title of certifier	and manner state	ed.			ense number				(Month, Day, Year)
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			e ress of person where E. Southall, MD	no completed cause Assistant Mo	of death (Iter	_{m 23a)} aminer 1	I11 Penn Str	eet, Baltir	more, MD 2120	1		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year Physician Mary 6:04 PM Hufford May 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Hospice Center Towson Gilchrist If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 💢 F 93 Yrs. 274-01-9423 Director January 19, 1914 OHIO Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 29a and any injury or other traumatic access. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1XYes 2 No Maryland Howard Director Columbia 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21044 5484 Ring Dove Lane USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ★No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White þ 3 ₩Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Manufacturing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Sherman Brown Eva Viola Bruce ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hufford / daughter Columbia, MD 21044 5484 Ring Dove Lane Patricia 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 Removal from State Anatomy Gifts Registry May 5,2007 Hanover, MD 4 Monation 5 ☐ Other (Specify) 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Funeral Service Licensee 7522 Connelley Drive suite P. Hanover, MD 21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) END STAGE ISEASE. 1003 **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ related to 2 No 1 Tes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy perioren Yes 2 e Hospital or Attending Physician: 24 hours after death. e Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natura! 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide TECertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 05/06

State

Registrar

555W. Towsentown Block

39. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

MAY 08

Faul (chermo)

32. Registrar's Signature

07-03466 Richa

Mec

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hydiene

2007 14760

sician/	Dag	or State	Cert	rtment of F tificate of L	Death		g. No.	3. Time of Death
	1. [Decedent's Name (First, Middle,Last)	11 1 1				Day Year	0743 hrs
aminer	_	Richard George Facility Name (if not institution, give st	Hall	4b	. City, Town, or Location of D		4c. County of Dea	ath
	4a.	1929 Susquehanna Hall Roa	ad		Whiteford		Harford	- (Ol-la er
	5.	Social Security Number 6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Year If Under 2		For	Birthplace (State or eign
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any	_	a. State 10b. County		Town or Location	n			1 Yes 2 No
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		63 Springside Dri	Ve 12. Was Decedent Ever in U.	s 13 Was	21093 Decedent of Hispanic Origin	? (Specify Yes or No	- 14. Race - An	nerican Indian, Black,
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Department of regula and Montae Important: If item 27 is marked injury or other traumatic event,		a Mathed of Diagonition	20b.	. Place of Dispos crematory or ot	ition (Name of cemetery,	Date	20c. Location - Cit	
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ING F 1951 can. After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial - tri	Certification: To Be Completed by Physician/Medical Exa	events resulting in death) Last d. X UNPENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknow Part II. Other significant conditions Chronic alcoholism 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 X Natural 5 Pending Investige 3 Suicide 6 Could not determine to the conditions of the could not determine to the conditions of the could not determine to the could not determine to the could not determine to the could not determine to the could not determine to the could not determine to the could not determine to the could not determine to the could not determine to the could not determine to the could not determine to the could not determine to the could not determine to the could not determine to the could not determine to the could not determine to the could not determine to the could not determine to the could not determine the could	23c. If yes, outcome of proceedings of the pregnant at time of g Unknown contributing to death but not to be (Specify) ation 28a. Date of Injury (Month, Day, Year) ation 28e. Place of Injury (Specify) sician: To the best of my knowner: On the basis of examination and manner stated.	regnancy f death 5	26.Place of Deatlent 3 DOA Other 4 of Injury 28c. Injury at Wo 1 Yes 2 treet, factory, office building, courred at the time, date and igation, in my opinion, death	Part I. 23e. D 24a. W an 1 ✓ Y h (Check only one) Nursing Home 5 rk? 28d. Desci No etc. 28f. Locati or Too place, and due to the occurred at the time, er	Month Id tobacco use contrib Yes 2 No 3 Vas an utopsy erformed? es 2 No 1 Residence 6 Tibe how injury occurre on (Street and Number, State) cause(s) and manner date and place, and contribute to the state of	Day Year oute to the cause of death? Probably 4 Unknown Vere autopsy findings availabrior to completion of cause of eath? Yes 2 No Other: Scene ed er or Rural Route Number, Citar as stated. due to the cause(s) ned (Month, Day, Year)

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) Dav Month Vear 25 **Physician** HARRIS MEYER 4,2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE If Under 1 Year If Under 24 Hrs. LEVINDALE HEBREW HOME N/A 8. Date of Birth 07/31/1925 7. Age (In yrs, last birthday) 9. Birthplace Country) (State or Foreign Days Hours Min. Months 220-18-9857 81 MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ¹**y**□Yes 2□No Director MD N/A BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2500 W. BELVEDERE U.S.A. ace - American Indian by Funeral AVENUE 14. Race 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: WHITE 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ ATTORNEY LAW 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ۵ JACOB HARRIS $TIII_YF$ BLOCK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) BEN KRUGER / NEPHEW SHELTON COURT - REISTERSTOWN, MD 21136 Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) HEBREW YOUNG MENS 05/06/2007 WOODLAWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., 21. Signature 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest, Immediate Cause (Final brovasc disease or condition resulting in death) ertens, ON Sequentially list conditions, the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of) Physician/Medical Examiner Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1∐ Yes 25. Was case referred to medical examiner? To Be 26. Place of Death (Check only on Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**X** No Hospital: Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA 27. Manner of Death 1 De Natural Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 Pending investigation Injury 1 Natural 2 Accident 1 TYes 2 🗌 No

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 After this

Funeral

Director

r 28a-f show notified at

ms 23a or 3

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

"natural"

ental Hygiene. Red other than "nature c event, the Medical E

27 is marked or traumatic ev

Department of Health Important: If item 27 any Injury or other tr

Physician

/Medical **Examiner**

Baltimore, Maryland 21215-0036

within 24 hours after death

To the Funeral Director:
completely filled in by the Registrar

30. Name and address of person who completed cause of death (Item 23a) Day, Year) 31, Date filed (Month,

6 Could not be determined

3 ☐ Suicide

29a, Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

Registrar's Signature

and manner stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

State

_			1 - For State Registrar			f Marylar	-	artment of rtificate o	Health and I		Reg. No.	200	7	14762
	Physici		Decedent's Nam James	e (First, Middle 6 Ches	, Last) ter Jone	s				2. Date of Dat		07 Ye	ar	3. Time of Death 1;17 Am
	/Medio Examir		4a. Facility Name (If not institution,	give street and nur	mber)		4b. City, Town	or Location of Deat	h		County of [
			Dulane	yTowso	n Nursing	Center	2	To	wson			altim	ore	
	Funeral Director		5. Social Security N 227-05-2	lumber	6.Sex 1 □ X M 2 □ F	7. Age (In yrs. 88		Months Day		8. Date of Bi (Month, B June 2	irth 19, 191	9. Vi	Birthpla Countr LTG11	ice (State or Foreign
	p .		Usual Residence o	f Decedent 10b. County		10c Ci	ty, Town or Lo	vention					100	d. Inside City Limits
	with the Maryland a or 28a-1 show Le notified at	ctor	MD		altimore	100.01		rkville						1 ☐ Yes 2½ No
	h with th	al Director	10e. Street and Nu 3417 Ad	^{mber} cton Ro	ad			10f. Zip Code 21	234		10g. Citi	zen of Wha USA	t Country	y?
9	within 72 hours after death with the Maryland ene. than "netural", or Items 23a or 28a-1 show re Madical Examiner mant be motified at	Funeral	11. Marital Status 1 ☐ Never Marr	ried 2∐ Marri	12. Was Dece Armed Fo ed 1 Xes If Yes, Giv	edent Ever in U rces? 2 No	ŀ	Was Decedent of Yes, specify Control of Yes 2 □	f Hispanic Origin? (Suban, Mexican, Puerl	pecify Yes or N o Rican, etc.)	0-	14. Race - A Black, V Specify:	White, et	
89	rali, o	d b	3 ₩ Widowed	4 ☐ Divorced	Year or D	ates:		1 162 SEAV	o specify.			эреспу:		
5-0	72 h	etec	(Spec	15. Decedent	's Education t grade completed)		16a. Dece (Give	dent's Usual Occ kind of work dor	cupation ne during most of wor ired)	rking		nd of Busin		-
121	vithin ne. han	Completed	Elementary/Seco	ondary (0-12)	College (1	1-4or 5+)	Weld		ired)					uction
2	be filed withintal Hygiene.	ပိ	17. Father's Name	(First Middle I	ast)		WCIC		18. Mother's Nar	ne (First. Middle		Compai	ııy	
and	ould be f Mental h arked of	Be		Jones					Elizabet			,		
Maryland 21215-0036	d 2 should be filed within the and Mental Hygiene. 77 Is marked other than traumatic event, tre Mental Head	ပ္	19a. Informant's N	ame/Relationsh	nip (Type, Print)		19b. Maili	ng Address (Stre	et and Number or Ru oad–Parkvi	ural Route Numb	ber, City or	Town, Sta	te, <i>Zip C</i>	iode)
re, N	s 1 and f Health item 27 other tr		20a. Method of Dis	position	r-daughte	20b. I	 Place of Dispo	sition (Name of	· 1	Date		cation - City		n, State
Baltimore,	permil. Pages 1 and Cepartment of Healt Important: If item 2 any injury or other GCCs.		` 4 ☐ Donation	5 ☐ Other (Sp		State EVA	CREMA	TERAL "CHATIONS—B	elair ///ay	7,2007		est I		
Bai	Cepar Cepar Impor eny in		21. Signature of Fe	uneral Service L	ME Ja	ddu	F	Name and Add VANS F ND CRE	UNERAL C MATION S	HAPEL ERVICE	8800 S	Har arkvi	for lle	d Road MD 21234
She Office	Physician /Medical Examiner		23a. Part1. Enter the shock, or head shock, or head shock and shock and shock are sulting in death)	(Final	- a. Acu	caused the deal sach line. (or as a consec	erel	ter the mode of d	tying, such as cardia	or respiratory a	n lu	oses	1	Approximate nterval Between Onset and Death
10 11	pit it	iner	if any, leading to in cause. Enter Undo Cause (Disease or	mmediate erlying	b. Due to	(or as a consec	quence of):						1	
7 -05	ate be executed hysician and the burial-transit	Ical Examiner	that initiated event resulting in death)	S	c Due to	(or as a consec	quence of):							
A スト O. Box 68	ne death certific the attending p thed for use as	Physician/Med	1F FEMALE: 23b. Was deceder in the past 12 1 ☐ Yes 2 9 ☐ Unknowr	nonths? □No	1 Live t	tcome of pregnointh 2 Pete nant at time of co	al death 3	⊒Ectopic pregnal ☑ Other (specify)			2	23d. Date of Month		y Day Year
ds, P.	uires that the signed by Id be detact	δ	Part II. Other signi	ficant condition	ns contributing to d	eath but not res	sulting in the u	nderlying cause	given in Part I.		tobacco u		te to the	cause of death?
mes ital Records,	e law requii has been s je 2 should	Completed	COK	CONA	ary A	RTE	RY	DISE	ASE		opsy	24b. Wer	e autops	sy findings available pletion of cause of
ي ۾		Son	PERI,	PHEI	RAL L	ASU	LAK	215	EASE	pen 1 □ Yes	ormed? 220 No	deat	n? Yes 2	: No
∑ /ita	i ician : Th certificate rector, pag	Be	25. Was case refe examiner?	rred to medical	Hin-		111		26. Place of Dea	ath (Check only	bne)			
25	Physician: this certificanal director,	은	1 🗆 Yes 2	V		Inpatient 2	-	IL 3 DOA		iome 5 ☐ Res			Specify)	
Sion	ding h. After fune	atlon	27. Manner of Dea 1 Natural 2 Accident	5 🗀 Pending investig	ation	of Injury th, Day Year)	28b. Time of Injury		ojuryat Vork? □Yes 2□No	28d. Describe				
NeS Divisio	al or Atto s after de l Directo d in by ti	Certification:	3 Suicide 4 Homicide	6 □ Could r determi	ned 288. Place	of Injury - At h ing, etc. (Speci		reet, factory, offic	Ce Co	28f. Location City or To	(Street and own, State)	d Number o	or Rural I	Route Number,
700	To the Hospital or Attenwithin 24 hours after deat Within 24 hours after deat To the Funeral Director: completely filled in by the	edical C	29a. Certifier (Check only one)		Examiner: On the b				time, date and place y opinion, death occu					
	To the within 2 To the comple	Me	29b. Signature and	title of certifier	21	,		29c. Lice	ense number		29d. Dat	e signed (N	fonth, Da	ay, Year)

29b. Signature and title of certifie 2-00 12849 who completed cause of death (Item 23a) (Type, Print)

201. M.D. 7600 OSLER Dr. TONSON MD 21204 AH. GHILADI. 31. Date filed (Month, Day, Year)

State Registrar

32. Registrar's Signature

5-5-07

			For State Registrar	State of Marylar	nd / Depa	artment of F	lealth and I Death		lene2007	14763
	Physici		1. Decedent's Name (First, Middle, Last,	Kelvin G. J	lacksoi	n. Sr.		2. Date of Deat Month	h Day Year May 2, 2007	3. Time of Death 3:40 a M
	/Medio		4a. Facility Name (If not institution, give			Т	r Location of Death		4c. County of Dea	th
	P. F.	4	110	10 Rhodenda Place			Upper	Marlboro	Princ	e George
	Funeral Director		5. Social Security Number 6. Sec. 1 214-78-6488 Usual Residence of Decedent	M 2□F	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Nov 1	Year) Co	thplace (State or Foreign ountry) Maryland
	e Maryland la-f show tified at	ctor	10a. State 10b. County Maryland Prince Geo	orge County	ity, Town or Lo		er Marlboro			10d. Inside City Limits 1 ☐Yes 2 ☐ No
	th with th 23a or 28 ust be no	ral Director	10e. Street and Number 11010 Rhodenda Place			10f. Zip Code	20772	1	0g. Citizen of What Co	ountry? S.A.
036	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mential Hygiene. If Item 27 Is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐ XNo	lispanic Origin? (S) an, Mexican, Puert Specify:	pecify Yes or No- p Rican, etc.)	14. Race - Ame Black, Whit Specify:	
21215-0036	vithin 72 ho ne. han "natur e Medical I	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occup e kind of work done o DO NOT use retired	ation during most of wor t) Analyst	king	16b. Kind of Business. General	/Industry Dynamics
and 5.	d be filed v ental Hygie ced other t c event, th	Be	12 17. Father's Name (<i>First, Middle, Last</i>)	own	<u> </u>			ne (First, Middle, I	Maiden Surname) se Jackson	
Maryland	nd 2 should th and Men 27 Is marke traumatic	ဥ	19a. Informant's Name/Relationship (Ty	pe. Print)	I	-			; City or Town, State, .	<u> </u>
Jore,	Pages 1 and 2 nent of Health a nnt: If item 27 I ury or other tra		20a. Method of Disposition 1 Deurial 2 Cremation 3 F		Place of Dispo cemetery, cre	osition (Name of matory or other plac	ce)	·	20c. Location - City or	
Baltimore,	permit. Pag Department Important: I any injury o		4 □ Donation 5 □ Other (Specify) 21. Signature of Oneral Service Licens	"N. Des		urrection Cem 2. Name and Addre Adams	ss of Facility Funeral Hon	ne, PA	<u> </u>	
1	Physician		23a. Part1. Enter the diam'se, or compleshock, or heart failure. List only of Immediate Cause (Final disease or condition		ath. Do not en	ter the mode of dyin	Aquasco Koang, such as cardiac	or respiratory arr	Maryland 2060 est,	Approximate Interval Between Onset and Death
1	/Medical Examiner		resulting in death) Sequentially list conditions.	Due to (or as a conse	quence of):					
1	be executed sician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unsease or injury that initiated events resulting in death) Last	Due to (or as a consect. Due to (or as a consect.)						-
,820,	ate the	lical		d.	quence oi).					
P.O. Box 6	The law requires that the death certific tte has been signed by the attending p bage 2 should be detached for use as i	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	⊒Ectopic pregnancy ⊒ Other (specify)	/		23d. Date of de Month	livery Day Year
	w requires that been signed b should be deta	by	Part II. Other significant conditions co	ntributing to death but not re	sulting in the u	inderlying cause giv	en in Part I.	23e. Did tol	pacco use contribute to	o the cause of death?
Division or Vital Records,		Completed						24a. Was a autops perfori 1∐ Yes	y prior to	utopsy findings available completion of cause of
Ĭ.	siciar certif recto	Be	25. Was case referred to medical examiner?	Hospital:	7500	nt all DOA Oth	OF:	th (Check only on		
ion or	Attending Physician: The robath. ector: After this certificate hey the funeral director, page	ation: To	1 Yes 2 No ' 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 28c. Injur Wor	4 LI Nursing H		ence 6 □Other (Spe ow injury occurred	cify)
Divis	or At after d Direc in by	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At h building, etc. (Spec	nome, farm, sti ify)	reet, factory, office		28f. Location (St City or Town	reet and Number or Ri , State)	ural Route Number,
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	edical	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	sician: To the best of my kn ner: On the basis of examin and manner stated.	nowledge, deat nation and/or in	th occurred at the tin envestigation, in my o	me, date and place opinion, death occu	, and due to the c rred at the time, d	ause(s) and manner as ate and place, and du	s stated. e to the cause(s)
	To the within 2 To the complex	M	29b. Signature and title of certifier	~ 0		29c. Licens	e number	2	9d. Date signed (Mont	
	1		30. Name and address of person who co	ompleted cause of death (Ite	m 23a) (Type.	Print)			1	

Registrar DHMH 17 Rev 1/2001

State

401 NURTH BROAWAY, BALTEMORE, MARYLAND

			Please Type or Print in Black State of Maryland / De	Indelible Ink. Ensure Al partment of Health and M	-	
			1 - State Registrar	ertificate of Death	Reg	j. No.
	Physici /Medio Examir	al	1. Decedent's Name (First, Middle, Last) Florine T. Jacobs 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	2. Date of Death Month	Day Year 9.4\$ A M
			Lorien Nursing Home 5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	Columbia If Under 1 Year If Under 24 Hrs.	D. Date of Dieth	Howard
	Funeral Director		230-22-8027 Usual Residence of Decedent	Months Days Hours Min	8. Date of Birth (Month, Day,) April 1.	(9. Birthplace (State or Foreign Country) 3, 1928 Virginia
	taryland show	or.	10a. State 10b. County 10c. City, Town o			10d. Inside City Limits 1 ☐ Yes 2 ☑No
	n the N r 28a-f	Irect	Maryland Howard Columb	10f. Zip Code	100	g. Citizen of What Country?
	s 23e c	eral D	10009 Herding Row	21046	N	USA
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23e or 28a-1 show eumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	 Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto Yes 2 No Specify: 	Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0036	"natura	Completed	(Specify only highest grade completed) (6	cedent's Usual Occupation ive kind of work done during most of work	ing 16	5b. Kind of Business/Industry
2121	d within giene. rr than	dmo:	Elementary/Secondary (0-12) College (1-4or 5+)	e. DO NOT use retired) achine Operator		Chemical Plant
nd	be filed stal Hyg od othe event,	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name		aiden Sumame)
aryla	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 Is marked any injury or other treumatic evonce.	2	Russell Alexander Temple 19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. M	Ruby Luc ailing Address (Street and Number or Rura	cille Ly]	
	and 2 ealth ar n 27 Is		Gary Jacobs, son 10	009 Herding Row Co	olumbia,	
Baltimore,	ages 1 nt of Ha t: If iter		Burial 2 Cremation 3 Removal from State	crematory or other place)		oc. Location - City or Town, State
altiu	mit. P. partme cortent / injury	i	04 01 14 14 14 14 14 14 14 14 14 14 14 14 14			Hopewell, VA
m	P S E E S		23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	Ambrose Funeral Hor 1328 Sulphur Spring	ne, Inc. ≥ Rd. Ar	butus. MP. 21227
Į,			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac of	respiratory arres	
	Pnysician /Medical		disease or condition resulting in death) a. Due to (or as a consequence of):	CULAR ACCIDEN	15	one book
	Examiner	20	Sequentially list conditions, if any, leading to immediate	iron		Jean
V	cuted nd transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events			
,097	e be executed /sician and e burial-transit	<u>a</u>	resulting in death) Last Due to (or as a consequence of):			
x 68	leath certificate attending physi ifor use as the	/Medi	IF FEMALE: 23c. If yes, outcome of pregnancy			
O. Box	The law requires that the death certificate ate has been signed by the attending phyroage 2 should be detached for use as the	Physiclan/Medic		3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
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ecords,	v require been sig should b		Innilia Dependent Diabela	Hellity.		2 望No 3 ☐ Probably 4 ☐ Unknown
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\	ysicien: Th s certificate director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	26. Place of Death		ce 6 □Other (Specify)
Division of	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	atlon: T	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) Injung 2 Accident investigation	of 28c. Injury at 2	28d. Describe how	
DIVIS	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town,	et and Number or Rural Route Number, State)
	e Hospi 24 hou etely fill	Medical	29a. Certifier 1 Scriffying Physician: To the best of my knowledge, di (Check only one) 2 Medical Examiner: On the basis of examination and/o and manner stated.	eath occurred at the time, date and place, a investigation, in my opinion, death occurre	and due to the caused at the time, date	se(s) and manner as stated. e and place, and due to the cause(s)
	To th within To th	Me	29b. Signature and title of certifier	29c. License number D 30469		Date signed (Month, Day, Year)
	5		30. Name and address of person who completed cause of death (Item 23a) (Ty NB VEUANK, 8850, COLUMBIA)	10. Print) Parkway # 30	8. Col	umbia, MD 21045
Ì	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 8 2007	1-5-		
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DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Physician P^{M} STANLEY **JACOBS** May 2007 2:27 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Greater Baltimore Medical Center Towson Baltimore 8. Date of Birth (Month, Day, Year 02/25/1926 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Days Hours 313-12-4226 81 INDIANA Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County r 28a-f show notified at 1 ☐ Yes 2 ☐ No Director MD BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? be r ms 23a 4500 CHAUCER WAY #202 21117 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 XIYes 2 Not VAVY If Yes, Give Year or Dates: WW II 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify. þ WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DIRECTOR UMBC BOOKSTORE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **JACOBS** MAURICE SCHWARTZ HELEN ٥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DONNA JACOBS / WIFE 4500 CHAUCER WAY #202 - OWINGS MILLS, MD 21117 20a. Method of Disposition Department of F Important: If ite any injury or ott OHEB SHALOW MEMORYAL 05/07/2007 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) REISTERSTOWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician nun DOYLO /Medical ust (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infine unate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Day 5 Other (specify) 1 □Yes 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an cate has page 2 s performe Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 10 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of ≰ertifier 29d. Date signed (Month, Day, Year)

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State

Registrar

Stret Tousan, MD

Modical

32 Registrar's Signature

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

MAY 08

			State of Maryland / Department of Health ar 1- State Registrer Certificate of Death	nd Ment	tal Hygie Reg.	4001	14767
			1. Decedent's Name (First, Middle, Last)		ate of Death	Day Year	3. Time of Death
	Physici /Medic		Nelle Reich		lay	4 200-	
	Examin	er			1	4c. County of Dea	h
	Funeral	-	5 Social Security Number 1 6 Sey 7 Age (In vrs. last hirthday) If Under 1 Year 1 If Under 24	4 Hrs. 8. D.	Date of Birth Wonth, Day, Ye	9. Bin	hplace (State or Foreign
	Director		2/5-24-79631 W 2XF 80 Yrs. Months Days Hours	Min. (A	3/08/19:	27 Wes	t Virginia
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	Maryl F sho	ţō	MD N/A Baltimore				1 □XYes 2 □ No
	th the	lrec	10e. Street and Number 10f. Zip Code		10g.	Citizen of What Co	ountry?
	ath wi	ral	1336 Hollins Street 21045			United	
9500-612	d within 72 hours after death with the Maryland jeine. Ir than "naturet", or tteme 23a or 28e-f show The Madical Examiner must be notified at	by Funeral Director	3 ∰Widowed 4 □ Divorced If Yes, Give 1 □ Yes 2 ☒ No Specify:	in? (Specify) Puerto Rican	Yes or No- n, etc.)	14. Race - Ame Black, Whit Specify: Wh	e, etc.
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yland	should be nd Mental marked o	To B	Harrison C. Lingenfelter Mar	mie Ma	rgaret	Carpente	r
Mar	2 sho		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number				
e,	1 and Heelth em 27		Joy L. Kelch (Daughter) 5858 Thunder Hill I	Road C		Lumbia, M Location - City or	
ē	pages ent of nt: If It		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1 Seminatory or other place) Western Cemetery	5/08/2			Maryland
Baitimore,	permit. Pages 1 and 2 should be Depertment of Heelth and Menta Important: if Item 27 is marked any Injury or other treumatic ex once.			Hubba	rd Fune	eral Home	. Inc.
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as ca shock, or heart failure. List only one cause on each line.			20, 121	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition				Onset and Death
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Š	cate be executed physician and the burial-transli						
04/80	cate be executed physician and s the burial-transit	dical	d			-	
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7	iaw requires that the as been signed by th 2 should be detache	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	2	23e. Did tobac	co use contribute to	the cause of death?
Sugar	en sig			_	1 🗆 Yes	2 No 3 P	obably 4 Unknown
al Kecords,	The far ete has page 2	Completed			24a. Was an autopsy performed I □ Yes 2 V	prior to death?	utopsy findings available completion of cause of 2 No
VITA	Physicien: Th this certificete ral director, pag	o Be	examiner?		eck only one)	0.50	
0	ding Phys h. After this funeral di	n: To	Thinbatient 2 acroombatient 3 DOA 4 Nots		Describe how i	e 6 □Other (Spe njury occurred	city)
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Division	rs after de al Directe ed in by t	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. L	ocation (Stree City or Town, S	t and Number or Ri tate)	ural Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death and manner stated.	place, and di n occurred at	lue to the cause the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To t To t	Σ	29b. Signature and title of Certifier 29c. License number		29d.	Date signed (Mont	h, Day, Year)
	•		20 Name and address of passes who applicated arms of death (law 202) Tara Paint	5L167	59 N	May 4	12007
	3		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Benjamin Lawner 22 South Greeke Street	- R	alto.	MD 2	1201
	Sta		31. Date tiled (Month, Day, Year) /32. Registrar's Signature				
*	Registr	ar	MAY 0 8 2007				

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State of Maryland / Department of Health and Mental Hygiene

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Medical Examine				ve street and number			4b. City, Town, o	r Location of			4c. County		
i .		Greater Bal	timore Medica	l Center			Towson		1			ore County	
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Director	ļ	217-06-1	378 12	M 2 F	į	51	Yrs. Months Da	ys Hours	1-	-11–19	56	Countr	y) India
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r death with the Maryland or items 23a or 28a-f show must be notified at once.			41st Stre	12. Was Deced	lest Ever in 115	c 13	Was Decedent of h	1211 Hispanic Origi	n? (Specify `	Yes or No-		ce - Americar	n Indian, Black,
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5-00 led wi stygie other		17. Father's Nam	e (First, Middle, La shwari P.	st) Khare				16.MOUTE	Krishn	a Khai	ce		
21215-0036 Juld be filed within 7 Mental Hygiene marked other than event, the Medica	8		Name/Relationship			[19b. M	ailing Address (St	reet and Num	ber or Rural I	Route Numb	er, City or T	own, State, 7	Zip Code)
O 2'should should Mind Mind Mins aftice	- 1	19a. Intormant's 1 Magdalene			ife	14	17 W. 41s	t Stre	et Ba	ltimo	re, Ma	arylan	d 21211
, MD and 2 sho ealth and em 27 is	- 5	20a. Method of D	isposition		20b.	Place of Di	sposition (Name of or other place)	cemetery,	Dat	е		on - City or To	
Ore		1 Burial 2	XXCremation				Crematory		5/4/2	2007	Cator	nsvill	e, Marylar
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation	5 Other Spec	ify:			22. Name and Addr	ess of Facility	y	moral	Homo	Tnc	
Bal permi Depar Impo injur		Mari	x Han	Dentu		_ 1	22. Name and Addr Burgee-He 3631 Fall nter the mode of dyi	nss-se s Roac	Balt	imore	, Mar	yland.	21211 Approximate Interva
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x 68 h certi tendin use a	<u>cia</u>	past 12 mor			ant at time of o	teath 5	Other (Specify)						
, P.O. Box 6876 res that the death certificate signed by the attending phy be detached for use as the b	Physician/M	1 Yes 2		9 Official		resultina i	n the underlying car	use given in F	Part I.				the cause of death?
P.O. es that the igned by			ignificant condition	ons contributing to	J GESTIT BUT THO	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	, ,			1 Yes	2 No	3 Prob	pably 4 🗸 Unknown
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Divisior To the Hospital or Attend within 24 bours after death To the Funeral Director: completely filled in by the	Cortification:	3 Suicide	deter	not be Specify					- 1	or Town,	state)		
Cospits hours linera ly fille				vsician: To the be	est of my knowl	ledge, deat	th occurred at the tir	me, date and	place, and du	e to the cau	se(s) and m	anner as sta	ted.
the II hin 24 the Fi	Madioal	(Check only one) 2	✓ Medical Exa	niner:On the basis and manner	of examinatio	n and/or in	vestigation, in my o	pinion, death	Occurred at t	ne time, date	Q.74 p.10-1-1		
To To con	1 5	29b. Signature	and title of certifie		Stated.			icense numb	er		1		onth, Day, Year)
		Drive	to Dretha	11.MD			(O.C.M.E.			May 2	, 2007	
. ^		30. Name and	address of person	who completed car	use of death (I	tem 23a)				01001			
12			E. Southall, N	1D Assistant	t Medical E	xaminer	111 Penn S	Street, Bal	timore, ML	7 2 1201			
	Sta	e 31. Date filed	(Month, Day, Year)	32. F	Registrar's Sigi	nature	Sperker						
Regis	str	ar	MAY 0	8 7001 .	Elegalistics 1	Mal	A CONTRACTOR OF THE PARTY OF TH						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Patricia Ann Knauer MODay 7. Z007 3:42A M /Medical 4c. County of Death
Baltimore 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Joseph Medical Center Towson Saint If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1 M XXF 219-70-1781 50 10-11-1956 Director Maryland Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 🏋 No Director Maryland Baltimore Nottingham 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code marked other than "natural", or items 23a or imatic event, the Medical Examiner must be r 9107 Moonstone Road 21236 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 ☐ Yes ※ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2XXNo Specify Specify: white à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker In own home 12 traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event 17. Father's Name (First, Middle, Last) Be Anthony Raab Patricia Salisbury 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Blane Knauer Husband 9107 Moonstone Road Nottingham, Maryland 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 □Cremation 3 □Removal from State Parkwood Cemetery 5/09/2007 4 ☐ Donation 5 ☐ Other (Specify) Parkville, Maryland 22. Name and Address of Facility Burgee—Henss—Seitz Funeral Home, 3631 Falls Road Baltimore, Mary Me of Funeral Service Liven Baltimore, Maryland 21211 ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e. List only one cause on each line. 23a. Part1. Enter the dise shock, or heart failu Immediate Cause (Final disease or condition resulting in death) Approximate Interval Between Onset and Death **Physician** MYOCARDIAL INFARCTION /Medical Due to (or as a consequence of): Examiner CORONARY ARTERY DISEASE Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and burial-trar Due to (or as a consequence of) physician Physician/Medical the as IF FEMALE ase If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy for L in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ RENAL FAILURE 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ▼ No 24a. Was an DIABETES certificate has autopsy 1∐ Yes Physiclan; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Tes 1 Inpatient 0 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Natural 5 Pending investigation Injury 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide

P.O. Box 68760. Records, Division or Vital

Baltimore, Maryland 21215-0036

pe Hospital or Attending Pl 24 hours after death. Funeral Director: After the 24 hours a

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State Registrar

Medical

KHOSROW TABASSI 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier

(Check only one)

M.D. 7601 32 Registrar's Signatu

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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OSLER DRIVE TOWSON.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D46356

29d. Date signed (Month, Day, Year)

21204

MARYLAND

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 6, Margaret Estelle Krumholtz May 2007 9:50 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Senior Constant Care Sykesville Carrol1 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1 □ M XX Days Hours 212-10-9435 90 Feb. 25,1917 Maryland Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f show must be notifled at 1 ☐ Yes XX No Carrol1 Sykesville Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21784 1200 West Old Liberty Rd. U.S.A. items 23a Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes X X No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □ Yes XX No Baltimore, Maryland 21215-0036 Specify: Completed by XXWidowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Assembly Worker Manufacturing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Thomas Bayne Ruby Gertrude Bayne ္က 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trai once. 1920 Knox Ave. Reisterstown, MD 21136 Marlene B. Moores / Niece 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lakeview
Memorial Park 20c. Location - City or Town, State 20a. Method of Disposition XXBurial 2 □ Cremation 3 □ Removal from State 5/9/07 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 21. Signature of Funer I Se an e Licensee 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. et and Death Immediate Cause (Final HSCVD **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, aftending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 Yes 2 ☑ 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) ASSISTED Hospital: 1 ☐ Inpatient 2/No 2 ER/Outpatient 3 DOA 1 ☐ Yes Certification: To LVING funeral 28a. Date of Injury (Month, Day Year) 27. Man of Death 28b. Time of 28c. 28d. Describe how injury occurred Injury at Work? After Injury 1 atural 5 Pending investigation s after dec. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title 29c. License number 29d. Date, signed (Month, Day, Year) D16206 2001 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PRIMARY CARE 1330 LD. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State MAY 0 8 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician 2007 Koehler May 6, 8:40 РМ Norma H. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Montgomery General Hospital Olney If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) January 3, 1920 9. Birthplace (State or Foreign **Funeral** Days Hours Months Country) Illinois 1 □ M 2 🔯 214-60-0340 87 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show 10a State 10b. County at 1 ☐ Yes 2 ☑ No be notified Director Silver Spring Maryland Montgomery 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 20906 United States 14400 Homecrest Road, #53 'natural", or Items 23a **Examiner must** hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify Specify: White þ 3 Widowed 4 Divorced Year or Dates: Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) within 72 | (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Healthcare 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ida M. Karolus Martin H. Hubrig 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alan Scott Koehler / Son 17707 Hidden Garden Lane, Ashton, Maryland 20861 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State May 8, 4 □ Donation 5 □ Other (Specify) Montgomery Crematorium, Inc. Bethesda, Maryland 2007 21. Signature of Funer Service Licensee 22 Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. M01305 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part 1. Enjoy the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Sepsis E. Coli /Medical Signoid Colon Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last certificate be executed physician and s the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical ding IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atten for u 3 DEctopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) ed by the a detached f 9 ☐ Unknown signed by t t be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Unpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury -(Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t or Attending 1.□Natural 5 Pending investigation s after deameral Director: After 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier **frectifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated.

P.O. or Vital Records, Division within 24 hours at To the Funeral C

tem 23a) (Type, Print) Name and address of person Olaadwood Ctoot ARTHUR F Woodera 31. Date filed (Month, Day, Year) 32 Registrar's Signature MAY 0 8 2007

29c. License number

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: this (After I Director: A filled in by within 24 hours a To the Funeral I

> State Registrar

Certification:

Medical

1 Natural

3 ☐ Suicide

29a. Certifier

2 Accident

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

5 Pending investigation

6 Could not be

Joelline Konakhou

08

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

KOUATCHOU

determined

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

AT 243 89 46

MEMBRIAL

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Me14 7

HOSPITAL

29d. Date signed (Month, Day, Year)

200

(Month, Day Year)

32. Registrar's Signature

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number 29b. Signature and title of certific D0061438 address of person who completed cause of death (Item 23a) (Type, Print) 5 3001 South Hanover St. Baltmere MD 21225 BUKOV: 12 INDREW 31. Date filed (Month; Day, Year) 32 Registrar's Signature State Registrar **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 4 BDay Physician May Gary Stephen Luerssen /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Medical en G Rurnit Center If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 55 Yrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Hours 212-58-0181 9-23-1951 MD **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 1 Yes 2 No Director MD Anne Arundel Severn 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ms 23a or 7 1631 Shannon O Circle 21144 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race · American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. r than "natural", or iter the Medical Examiner 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify white þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) t of Health and Mental Hygiene.
If Item 27 is marked other than
or other traumatic event, the M 4 Business Analyst Lockheed Martin 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Richard Luerssen June Luerssen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mrs. Dawn Luerssen/ Wife PO Box 378; Odenton, MD 21113 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c Location - City or Town, State 20a. Method of Disposition May 5 Date Department of H Important: If Itel any injury or otl once. 1 ☐ Burial 2 【ICremation』 3 ☐ Removal from State Chesapeake Cremation | 2007 5 Q Other (Specify) 4 Donation Stevensville, MD 22. Name and Address of Facility 21. Signature Licensee 1 Second Ave. SW M01411 Singleton Funeral Home; Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nsequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown been signed by should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 2 No 1 TYes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

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State Registrar 31. Date filed (Month, Day,

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29b. Signature and title of certifier O.C.M.E. May 5, 2007 30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Д.	res ti signe be d														- 100	3575		200000000000000000000000000000000000000
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			1 - For State Registrar	State of Maryla		ent of Health ate of Deati		ntal Hygien	2001	14775
	Physici /Medio Examin	al	1. Decedent's Name (First, Middle, Las 0.000 + 4a. Facility Name (If not institution, give	street and number)	4b. C	City, Town, or Location	1, Jr. 1	hay 5	e. County of Dea	3. Time of Death
	Funeral Director		5. Social Security Number 6. Social Security Number 1 213-36-1851 Usual Residence of Decedent	Dopkins Ho	s. last birthday) If Ut		er 24 Hrs. 8.	Date of Birth Month, Day, Yea eb. 22, 1	9. Bin 941	hplace (State or Foreign ountry) Ohio
	death with the Maryland ms 23a or 28a-1 ehow Linust be notified at	Director	10a. State 10b. County Maryland Baltimo			NSON . Zip Code		100.0	Citizen of What Co	10d. Inside City Limits 1 ☐ Yes 2 💢 No
36		by Funeral Di	706 Scarlett Driv 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	U.S. 13. Was D	21286 ecedent of Hispanic C specify Cuban, Mexic			U.S.A 14. Race - Ame Black, White	ncan fndian,
21215-0036	s filed within 72 hours after I Hygiene. other then "natural", or Ite ont. the Madical Examina	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation	16a. Decedent's la (Give kind o life. DO NO	f work done during me T use retired) Agent		La U.	Kind of Business W Enford S. Gover	Industry ement
Maryland	d 2 should be fill the and Mental H. 7 ie marked oth traumatic even	To Be	17. Father's Name (First, Middle, Last) Robert 19a. Informant's Name/Relationship (7)	J. Lally		ress (Street and Num	Margar		l. Mi	ller
	es 1 and 2 of Health a fitem 27 id r other tra		Karen A. Lally 20a. Method of Disposition 1 XBurial 2 Cremation 3	Wife 20b.	706 Sca Place of Disposition cometery, crematory Lianey Val	arlett Dri	ve 7	Towson, M	laryland Location - City or	21286 Town, State
	permit. Pag Department important: i any injury o		4 Donation 5 Other (Specify 21. Signature of Funecal Service Licen	see	Memorial Ga	ardens e and Address of Fac 50 York Ro	Nuci		Funeral	Maryland Home, Inc. 21204
	Physician /Medical Examiner physician up prize physician and physician and physician at the prize physician at the prize physician physi	dicai Examiner	23a. Part1. Enter the disease, or compands,	Due to (or as a consect. Due to (or as a consect. Due to (or as a consect. Due to (or as a consect. Due to (or as a consect. Due to (or as a consect. Due to (or as a consect.	c card equence of): Ve Ly	iac Ar	rest rest	-		Approximate Interval Between Onset and Death 10 m: nute Thouse
.O. Box 68	requires thet the death certifica een signed by the attending pl hould be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3 □Ectop	ic pregnancy (specify)			23d. Date of de Month	ivery Day Year
2.	w requires thet been signed b should be deta	Ď	Part II. Other significant conditions of	ontributing to death but not re	esulting in the underlyi	ng cause given in Par	t I.			o the cause of death?
tal Mec	The law ate has b page 2 s	e Completed	25. Was case referred to medical			ae Ble	and of Dooth (C	24a. Was an autopsy performed? 1 Yes 2 N Check only one)	death?	utopsy findings available completion of cause of
<u> </u>	d is	To B	examiner? 1 ☐ Yes 2 💓 No	Hospital: 1 Inpatient 2	☐ ER/Outpatient 3☐	Othor		5 ☐ Residence	6 ☐Other (Spe	city)
VISION	ii or Attending Ph after death. Director: After th d in by the funeral	Certification:	27. Manner of Death 1 On Natural 2 Accident 3 Surcide 4 Homicide 2 Homicide 5 Pending investigation 6 Could not be determined		28b. Time of Injury M home, farm, street, facility)	28c. Injury at Work? 1 ☐ Yes 2[□No	Location (Street City or Town, Sta	and Number or Ri	ural Route Number,
٥	Hospita 4 hours Funerei	Medicai Ce	29a. Certifier (Check only one) 1 Certifying Ph	ysician: To the best of my kr tiner: On the basis of examinand manner stated.	nowledge, death occur nation and/or investiga	rred at the time, date tion, in my opinion, d	and place, and eath occurred	I due to the cause at the time, date a	(s) and manner as nd place, and due	stated. to the cause(s)
ı	To the To the complet	M	29b Signature and title of certifier			29c. License numbe	_		ate signed (Mont	
5	Sta	L	30. Name and address of person who of the same and address of the	32. Hogistrar's Sign	SOURE ST.	BALTIMAE,	_	1287		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Day **Physician** 2:55 P M Loen May 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5816 Alderleaf Place Columbia Howard If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year) July 25, 1932 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours M 2□F New York 74 168-24-2119 Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. em 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10b. County r 28a-f show notified at 10d. Inside City Limits 1 ☐ Yes 2 Mo Director Columbia Maryland Howard 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? r than "natural", or Items 23a or the Medical Examiner must be r 5816 Alderleaf Place 21045 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3 ☐ Widowed 4 ☑ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Real Estate Agent Real Estate 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Department of Health and Menimportant: If item 27 is marker any injury or other traumatic e Hans Loen Margaret Machtig ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cecelia M. Wright (Companion) 5816 Alderleaf Place Columbia, MD 21045 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 5 ☐ Other (Specify) Metro Crematory Catonsville, MD 4 □ Donation 05/04/2007 22. Name and Address of Facility Witzke Funeral Homes, Inc. 21. Signature of Funeral Service License 5555 Twin Knolls Road Columbia, MD 21045 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Rectal Month s **Physician** Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) signed by the a 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Prosta 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 2 Unknown been si should I Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed' Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA ၉ 1 ☐ Inpatient funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🗌 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29b. Signature and title of ce 29c. License number 29d. Date signed (Month, Day, Year)

\0 State

Registrar

Wells

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

North Breadway

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

401

2. Registrar's Signature

Messersmith

Year)

00057802

Baltimore Maryland

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		For State Registrar	/lental Hy	ental Hygiene									
	wiji	Hegistrar Decedent's Name (First, Middle, L	ast)		001	rtificate	- 1	Jean	2. Date of De			3. Time o	f Death
Physicia /Medic		Mauri	ce Joseph	Lyn	nch				Month May	6, Da	2007 Year	7:06	A M
Examin	_	4a. Facility Name (If not institution, ga	·					Location of Death	4c. County of Death				
		Montgomery Gene 5. Social Securify Number 6.			last birthday)	If Under 1)lne	ey If Under 24 Hrs.	9 Data of Bi		Montgom		
Funeral Director		5. 500al Security Number 6.	17☑M 2□F	75	Yrs.		Days	Hours Min.	8. Date of Bi (Month, Day 3,	ay, Year,) Co	thplace (State ountry) nington	· ·
Ð		Usual Residence of Decedent							may J,	173	Z Wasi		
arylar show	<u>-</u>	10a. State 10b. County		10c. City	y, Town or Lo							10d. Inside C	ity Limits
the M 28a-f notifie	recto	Maryland Montgo	mery		Bethe	sda 10f. Zip Co	nde			10g Ci	tizen of What Co		- ДПО
filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or Items 23a or 28a-f show ent, the Medical Examiner must be notified at	Funeral Director	7514 Spring Lak	e Drive. U	nit A		1011 2.19 00		20817			ited Sta	-	
death	nera	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.		Was Deceden		ispanic Origin? (Sp In, Mexican, Puerto	ecify Yes or No		14. Race - Ame	erican Indian,	
s after	by Fu	1 X Never Married 2 Married	1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:		1	1 □ Yes 21 <mark>∑</mark>		Specify:	riioari, etc.,		Black, Whit	White	
hours tural	ed b	3 Widowed 4 Divorced			16a, Dece	dent's Usual C	Occun	ation		16b K	and of Business		
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d Mer marke	၉	John Joseph Lyn 19a. Informant's Name/Relationship			19h Mailin	a Address /S	troot	Margare and Number or Rui				Zin Codo)	
nd 2 s ilth an 27 is r trau		Jeannine de S. L	C) L)					ke Drive,					817
ss 1 a of Hea item	Ì	20a. Method of Disposition		20b. P	lace of Dispo	sition (Name	of		Date 9		ocation - Cify or		511
Page ment ant: If ury o		1 M Bunal 2 ☐ Cremation 3 department of a line of the second of the sec		Park	clawn Me	morial I	Park	200		Roc	kville,	Mary1a	and
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Lice	ensee	2001	Ro Ro	Name and A bert A.	Addres	ss of Facility phrey Fune:	al Home/	Beth	esda-Chev	y Chase,	Inc.
BD = 80	-	23a. Part1. Enter the disease, or co	nnlications that caused		305 75	57 Wisco	nsi	n Avenue, I	Bethesda,	Mary	rland 208	14-3501 Approxima	
		shock, or heart failure. List onl Immediate Cause (Final	y one cause on each li	ne.						2,1001,		Interval Be Onset and	tween
/Medical		disease or condition resulting in death)	Due to (or as	a consequ	uence of):	spi ru	FIL	Det)					
Examiner		Sequentially list conditions.	b. Conge	340	ie to	cent		Hailus	re	_			
ist Aleg	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated overts.	Due to (or as	a consequ	uence of):	21/02	V:	oa) failu ou					
executed in and ial-transit	Exan	that initiated events resulting in death) Last	Due to (or as	a consequ	uence of):	e acc	600	yen					
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ertifica ing ph	Med	IF FEMALE:											
attendi for use	jan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	2 Fetal	Ideath 3□	Ectopic pregr					23d. Date of de Month		Y <i>e</i> ar
the de	by Physician/Medica	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	t time or de	eatri 5L	Other (speci	(IV)						
s that ned b e deta	y P	Part II. Other significant conditions	contributing to death b	ut not resu	ulting in the ur	nderlying caus	se give	en in Part I.	23e. Did	tobacco	use contribute to	the cause of	death?
equire en sig ould b	ed b								1 🗆	Yes 2	ØNo 3□P	robably 4 🗌	Unknown
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g Phy er this eral d	n: To	27. Manner of Death	28a. Date of Inju	iry	28b. Time of Injury		Injury Work		28d. Describe		6 ☐Other (Spe ry occurred	cify)	
endin eath. or: Aff he fur	atio	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not	on	, , , , ,	injury	М		Yes 2 □ No					
or Att	Certification:	3 Suicide 6 Could not 4 Homicide determined		ury - At ho c. <i>(Specif</i> y	me, farm, stre	eet, factory, o	ffice		28f. Location (City or To	Street ar wn, State	nd Number or Re e)	ural Route Nur	nber,
spital ours a neral I		29a. Certifier 1 Certifying P	hysician: To the best	of my know	wledge, death	n occurred at t	the tim	ne, date and place,	and due to the	cause(s	and manner as	s stated.	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check only 2 ☐ Medical Exa	miner: On the basis o and manner sta	f examinat	tion and/or in	vestigation, in	my or	ninion death occur	red at the time	date an	d place and due	e to the cause(3)
With To	2	29b. Signature and title of certifier	Hospi	face	list	29c. Li	icense 00	number 15991 Nilip Di	4	29d. Da	te signed (Mont	h, Day, Year)	
م		30. Name and address of person who	completed cause of d	leath (Item	23a) (Type	Print) MUCE	P	hilip Di	r. Ol	ney	MI	208	32
Sta Registr		31. Date filed (Month, Day, Year)	327Registr	ar's Signa	ture	a Ba		9 =		0			
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within 2

State Registrar

31. Date filed (Month, Day, Year, 08 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



and manner stated.

m.D.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D56531

29c. License number

29d. Date signed (Month, Day, Year)

MAY 2, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death May 5, William L. Molloy 2007 7:35 Ам 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Towson Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
July 23,1920 Birthplace (State or Foreign Country)

Maryland **№** M 2□F Months Days Hours Min 86 212-09-0230 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Parkville Baltimore 1 ☐ Yes X ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21234 2915 Erie Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 월 ☐ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Gibson-Homan Elementary/Secondary (0-12) College (1-4or 5+) Lab Technican 17. Father's Name (First, Middle, Last)
William L. Molloy 18. Mother's Name (First, Middle, Maiden Surname) Mary M. Coffey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 604 South Decker Avenue-Baltimore, Maryland 21224 19a. Informant's Name/Relationship (Type. Print) Patricia Weaver-niece 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Gardens Gregatory From Explace)
Cemetery 1 XBurial 2 ☐ Cremation 3 ☐Removal from State May 8,2007 Rosedale, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
EVANS FUNERAL CHAPEL 8800 Harford Road Parkville, Maryland 21234 AND CREMATION SERVICES 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cau je on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final HEPATOCEL disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Hary, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dies to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 Yes 2 No 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

permit. Pages 1 and 2 should be filed.
Department of Health and Mental Hygin Important if tiem 27 is marked any injury or other the **Physician** /Medical Examiner 200 Box 68760. S

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Division or Vital Records,

Physician

/Medical

Examiner

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notified at

"natural", or items 23a or

other traumatic event, the Medical

and Mental Hygiene.

Directo

Funeral

Completed by

Be

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Examiner

Physician/Medical

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Certification:

Medical

29b. Signature and title of certifier

0 8

filed within 72 hours after death with the Maryland Hygiene.

Baltimore, Maryland 21215-0036

nding physician and

The law requires that the death certificate be executed signed by the a To the Hospital or Attending Physician: : After thi within 24 hours after death

To the Funeral Director:
completely filled in by the

		1 Yes 2 No 3 Probably Unknown
		24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1 ☐ Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	e 5 ☐ Residence 6 DiOther (Specify) HOSP, CR
27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	(Month, Day Year) Injury Work?	d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier Check only one) Check only	ysician: To the best of my knowledge, death occurred at the time, date and place, an niner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated	nd due to the cause(s) and manner as stated. d at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 555W 31. Date filed (Month, Day, Year)

32. Registrar's Signature

07-03328 Jarvis Moore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 14781

IVIS MOOIE		1- For State Criticate Certificate		Reg. No.	
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)		2. Date of Death	3. Time of Death
al Examiا الم		Javis L. Moore, Jr.		May 1, 2007	13151115
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. Cour	nty of Death
		13300 Cherry Tree Crossing	Brandywine		e George's
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs Months Days Hours Min	_	YYY) 9. Birthplace (State or Foreign
Director	ŀ	213-08-3944 1XM 2 F 30	rrs. World's Days Hodis Will	2/23/1977	country lorado
_		Usual Residence of Decedent 10a State 10b County 10c City, Town or Loc	action		10d. Inside City Limits
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ath wi	Funeral Director	1 V Never Married 2 Married Armed Forces?	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.) V	Vhite, etc.
ter de		3 Widowed 4 Divorced If Yes, Give Year 1	Yes 2XX No specify:	Spec	ty: Black
urs af tural	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent	dent's Usual Occupation (Give kind of g most of working life. DO NOT use ref		of Business/Industry
5-0036 led within 72 hours Hygiene I other than "natur the Medical Exam	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)	g most of working life. DO NOT use re-		71
5-0036 ed within 7/ tygiene other than	mp		Welder	Pier	ce Associates
5-0 iled v Hygid d other	ပ	17. Father's Name (First, Middle, Last)		e (First, Middle, Maiden Sum	
21215-0036 uld be filed within 7 Mental Hygiene marked other than c event, the Medica	Be C	Jarvis L. Moore, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Ma	Agnes iling Address (Street and Number or	L. KODINSON Rural Route Number, City or	Town, State, Zip Code)
MD 2 nd 2 shoul lith and h m 27 is m	To				
and 2 should and N tealth and N tiem 27 is n traumatic			15 Angora Dr.,	Date 20c. Local	tion - City or Town, State
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland bepartment of Health and Mornell Hygiene from Fire In programs. If item 27 is marked other than "natural", or items 23a or 28a-f she injury on other traumatic event, the Medical Examiner must be notified at once		1 X Burial 2 Cremation 3 Removal Iron State	rotherplace) <u>UMC Cemeterv</u> 5/	12/2007Brar	ndywine Md
Itim it. Pa urtmen prtant		4 Donation 5 Other Specify: ASDURY 21. Sign r Funeral Service Licensee	2Name and Address of Facility Adams Funeral	Hama DA	Idywine, ma
Balti permit. Departr Import	11	1 / Min 875	20605 Aquasco	RdAguasco	Md. 20608
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Vedical	1	failure Ust only one cause on each line Immediate Cause (Final disease a Contact Gunshot Wound of Hea			Death
kaminer		or condition resulting in death) Due to (or as a consequence of):			
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S, P.C uires that an signed I	Pa	W 		-	24b. Were autopsy findings available
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of Vit ng Physic After this	2	1 V Yes 2 No		28d. Describe how injury of	occurred
J of Ling F After	Ë			Subject shot self	
VISIOI or Attendather death Director:	cati	2 Accident Investigation 28e. Place of Injury - At home, farm,		28f. Location (Street and	Number or Rural Route Number, City
Division of Vital Records, spittal or Attending Physician: The law requir hours after death. Internal Director: After this certificate has been so willed in by the funeral director, page 2 should be a fear this control of the funeral director, page 2 should be a should	Certification:	3 V Suicide 6 Could not be determined (Specify) Unpaved Road		or Town State)	ssing, Brandywine, MD
Division of Vital Rec To the Hospital or Attending Physician: The I Jorihin 24 hours after death. To the Funeral Director: After this certificate I	၂ ပိ		occurred at the time, date and place, a	nd due to the cause(s) and m	nanner as stated.
To the II Within 24 To the F	Medical	(Check only one) 2 ✓ Medical Examiner: On the basis of examination and/or investant and manner stated.	stigation, in my opinion, death occurre	d at the time, date and place,	and due to the cause(s)
] §	29b. Signature and title of certifier	29c. License number	29d. Dat	e signed (Month, Day, Year)
$\bigcirc (5)$		Paratid myshull out	O.C.M.E.	May 2	, 2007
- 1		30. Name and series of person who completed cause of death (Item 23a)			
4	1	Pamela E. Southall, MD Assistant Medical Examiner	111 Penn Street, Baltimore	, MD 21201	
	State	31. Date filed (Month, Day, Year) 32. Refistrar's Signature	Course	-	
Regi	stra	MAY 0 8 2007 Meseuce At	The state of the s		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year 8:35 Mav 2007 4b. City, Town, or Location of Death 4c. County of Death Ellicott City Howard If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days | Hours | Min. Aug 3, 6 Sex 7. Age (In yrs. last birthday) 1 M 2 K 74 Mary Tand 10b. County 10c. City, Town or Location Howard Ellicott City 10f. Zip Code 10g. Citizen of What Country? 21043 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 🗓 No Specify: Specify: White 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
Dental Assistant 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Health Care

items 23a or 28a-f show ner must be notifled at "natural", or items 23a hours after death the Medical filed within 72 than permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hyglen. Important: if Item 27 Is marked other the any injury or other traumatic event, the i once.

Baltimore, Maryland 21215-0036

Funeral

Director

Physician /Medical Examiner

that the death certificate be executed sician and burial-trans attending physician for use as the buria ed by the page 2 s certificate

After To the Hospital or Attending s after dec... within 24 hours after des To the Funeral Directo completely filled in by th

Division or Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year)

32 Registrar's Signature

ORIGINAL

Physician Joan Virginia Meyer a M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 10025 Waterford Drive 5. Social Security Number 9. Birthplace (State or Foreign 212-30-4674 Usual Residence of Decedent 10d. Inside City Limits MD Director 1 ☐Yes 2 ☐No 10e. Street and Number 10025 Waterford Drive Funeral 11. Marital Status 1 Never Married 2 Married þ 3 XWidowed 4 ☐ Divorced Completed Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Earl Wisenauer Anna Clayton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Hyle/Daughter 10025 Waterford Drive Ellicott City MD 21043 20b. Place of Disposition (Name of cemetery, crematory or other place)
West Arundel Crematory 5-5-2007 20a. Method of Disposition 20c. Location - City or Town, State T□ Burial 2 ☑ Cremation 3 □ Removal from State Odenton, Maryland 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Affibrose funeral Home, Inc. 10/2/1328 Sulphur Spring Rd. Arbutus MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Breast Cancer Due to (or as a consequence of): Sequentially list conditions, if any least the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 🗌 Yes 2 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 24a. Was an autopsy 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Sesidence 6 Other (Specify) Hospital: 1 ☐ Yes No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D51018 nul 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Douglas Pinto, MD 3421 Blenson Ave., Bultimore, MD 21227 3421

DHMH 17 Rev 1/2001

			For Stata Registrar		State of	Marylan		artment <i>rtificate</i>			IG IVIE	-	giene Reg. No.	07	14783
			1. Decedent's Name (F	First, Middle, L	.ast)							2. Date of De			3. Time of Death
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	Examin		4a. Facility Name (If no	ot institution, g	ive street and num	ber)		4b. City, T	own, or	Location of I	Death		4c. Cou	nty of Deat	
			Genesis E	lder C	are Hammo	nds La	ne	Brool	k1yn	Park			Anı	ne Ar	undel
	Funeral		5. Social Security Num	iber 6.		7. Age (In yrs.			Year Days	If Under 24 Hours	Hrs.	8. Date of Bir (Month, Da	th V Year)	9. Birt	hplace (State or Foreign buntry)
	Director		216-14-114	9	1 □ M 2 💢 F	95	Yrs.	MOTHITS	Days	riours	10141.	July 1	0, 191	1	MD
	pu »		Usual Residence of De 10a. State 10	ecedent 0b. County		100 Cit	y, Town or L								10d. Inside City Limits
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	with t	2	10e. Street and Number		no			10f. Zip (10g. Citizen		ountry?
	within 72 hours after death with the Maryland ane. then "naturel", or items 23s or 28s-f show the Medical Exacitor man be notified at	Funeral		nus Lai			5 40		1225		0.40		U.S.A		The state of the s
	er de Item	nu	11. Marital Status	O Adomina	12. Was Deced	ces?	.5. 13.	If Yes, speci	fy Cubai	spanic Origin n, Mexican, F	Puerto R	city Yes or No tican, etc.)	14. F	lack, White	encan Indian, e, etc.
36	rs aft	by F	1 ☐ Never Married 3 🖫 Widowed 4 [1 ☐ Yes If Yes, Give Year or Da	5 1 1 100		1 ☐ Yes 2	X No	Specify:			Spe	city: Wh	nite
21215-0036	hou	ed		5. Decedent's		163.	16a Dece	dent's Usual	Occupa	ntion			16b. Kind of	Rusiness/	Industry
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77	filed withi Hygiene. other ther	E	Elementary/Seconda	ary (0-12)	College (1-	40r 5+)	Home	maker					Own	Home	
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Maryland	2 should be it and Mental I is marked or eumatic eve	-	19a. Informant's Name	a/Relationship	(Type, Print)		19b. Maili	ng Address (er, City or Tov	vn, State, 2	Zip Code)
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ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 21 ate of Maryland, Deposit worth Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 00 P M 30 Charlotte E. 2007 McComb /Medical 4b City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Pattimore Square HOSPITA 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 😿 F Months Hours Min. 62 Yrs. Director 212-42-0821 June 8, 1944 Baltimore, MD Usual Residence of Decedent 10a. State 10c. City, Town or Location r 28a-f show notified at 10b. County 10d. Inside City Limits 1 ☐ Yes χ ☐ No Director MD Baltimore Rosedale the 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code a or must b Breslin Court Apt. 1D 21237 USA permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23, any injury or other traumatic event, the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 years Own Home Housevi fe 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Mayerhofer Edith Ciamarra ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 Breslin Court Apt 1D Rosedale, MD 21237
Disposition (Name of Date 20c. Location - City or Town, State Larry В. **McComb** Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State **Bayview Crematory** May 5, 2007 Baltimore City, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 7110 Sollers Point Rd., Dundalk 21. Signature of Funeral Service Licensee Connelly Funeral Home of Dundalk, P.A. Anthony Connelly per dvr 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) nisease **Physician** Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physiclan; The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical as attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) by the a I Yes 2 No 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has e 2 certificate ha autopsy performer 1 TYes 1∐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only onle) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 □ DOA 일 1 Inpatient this 28a. Date of Injury (Month, Day Year) funeral 27 Mapner of eath 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: After Injury Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death

To the Funeral Director:.

completely filled in by the 1 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**Bedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) usky MO 30. Name and address of person who completed cause of death (Item 23a) Type, Print) 2899 Boston St. Bultimore Melvin Welinsky 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

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2007

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Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	w *			23a. Part I. Enter the disease, or com	iplications that caused the death. D	o not enter the	e mode of dying	, such as ca	ardiac or resp	iratory arre	st, shock, or hea	Approximate Interval Between Onset and	
The form of the contribution of the contributi	1	Ar dical	1	Immediate Cause (Final disease	Acute coronary th	rombosis						Death	
The form of the contribution of the contributi													
The standard of the standard o			ner	If any, leading to immediate									
The process of the pr		ed nsit	Exami	(Disease or injury that initiated									
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1		P.C es that igned be deti	l g										
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25. Was case referred to medical examiner? 1		e law	l m										
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			1 _ State	State of Mar	-	epartment of F		, ,			
			Registrar 1. Decedent's Name (First, Middle, Last)			Certificate of	Dealli	2. Date of Deat	eg. No.	0.7	3 Time of Death
	Physici /Medio		Juanita Bierau	McIntosh				Month May	Day	Year 007	11:45AM
	Examir		4a. Facility Name (If not institution, give st	,			or Location of Death		4c. County	of Death	
		7	5502 Harris Farm		I ((ksville	Lo Data d'Allah		Howai	
	Funeral Director		5. Social Security Number 354-01-4193 Usual Residence of Decedent	M 242 F	In yrs. last birt	Yrs. Months Days	Hours Min.	8. Date of Birth (Month, Day, Dec. 21	Year)	Cour	place (State or Foreign htry) Land
	yland how at		10a. State 10b. County	1	0c. City, Town	or Location		-		1	0d. Inside City Limits
	ne Mar 8a-f sl ptiffed	Director	Maryland Carroll		Wo	odbine					1 □Yes 2 21No
	with th	Dir	10e. Street and Number 16000 Frederick	Road		10f. Zip Code	21797	1	0g. Citizen of V U.S.Z		ntry?
	ms 2; mus	Funeral		2. Was Decedent Eve	er in U.S.	13. Was Decedent of H		ecify Yes or No-	14. Race	e - Americ	an Indian,
39	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates:		If Yes, specify Cub		Rican, etc.)	Specify	k, White, '' Whi	
ŏ	72 hou	ted	15. Decedent's Educa (Specify only highest grade	ation	16a.	Decedent's Usual Occup		ina	16b. Kind of Bu		
Maryland 21215-0036	vithin 7 ne. han "r e Med	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	7.0	(Give kind of work done life. DO NOT use retire	during most of work d)	arig	7.000.00	L 2	
22	Hygie Hygie Iher th	ပိ	17. Father's Name (First, Middle, Last)		AC	countant	18. Mother's Nam	e (First Middle II	Account		
an	d be ental ked o	To Be	Ludwig Bierau					.ara Wort		,	
ary	shoul ind M i marl	F	19a. Informant's Name/Relationship (Type	e. Print)	19b.	Mailing Address (Street					Code)
ž	and 2 alth a 27 is er tra		Peter J. McIntosh,	Sr. (Son) 16	000 Frederi	.ck Road	Woodbine	e, Mary	land	21797
altimore,	ages 1 and tof He it fitem	1	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	moval from State	cemeter	Disposition (Name of y, crematory or other pla	ce)		20c. Location -	-	own, State
Ħ	artmer ortant Injury		4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee			u & Resch I			Memphis		Tnc
Ba	Deperment of the second of the		Msk. Hader	na	050	5555 Twin					
₹;	50		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the cause on each line.	e death. Do n	ot enter the mode of dy	ng, such as cardiac	or respiratory arre	est,		Approximate Interval Between
9	Physician		Immediate Cause (Final disease or condition	A cute Due to (or as a c	Rena	1 failure				1:	Onset and Death
	/Medical Examiner	Ш	resulting in death)	Due to (or as a c	consequence o	f):	. 0-	11210			· · ·
0	- Adminion	<u></u>	Sequentially list conditions, b.	Due to for as a c		don't Dra	belly Me	ellihu			Han
シ	uted J ansit	Examiner	if any, leading to inimediate cause. Enter Underlying Cause (Disease or injury that initiated events			-,-					
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8760,	ate be	dical	d.								
9 X	The law requires that the death certificate has been signed by the attending plage 2 should be detached for use as to	Physician/Me	IF FEMALE: 23	c. If yes, outcome pf	pregnancy	-			and Dat		
Вох	death atter	ciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No	1 ☐Live birth 2 4 ☐ Pregnant at tir	Fetal death	3 ☐Ectopic pregnanc 5 ☐ Other (specify) _	у		Moi	te of delive nth	Day Year
P.O.	at the de by the a tached	hys	9 ☐ Unknown	9□Unknown							
S,	iw requires that s been signed b should be deta	by P	Part II. Other significant conditions conti	ributing to death but i	not resulting in	the underlying cause give	en in Part I.	23e. Did tob	/	ribute to th	ne cause of death?
ord	equir	bed	HYPERTENSION	lar Dir				1 □ Y∈	es 2 No	3 Prob	ably 4 Unknown
Vital Records,	has be pe 2 sh	Completed		Jan Dir	محود			24a. Was ar autops	y r	orior to co	psy findings available mpletion of cause of
<u>e</u>	Physician: The la r this certificate has ral director, page 2		Dementia.					perform 1 Yes 2		death? I □ Yes	2 № No
<u> </u>	siciar certif rector	Be	25. Was case referred to medical examiner?	spital:		nationt 3 DOA Oth	26. Place of Deat	h <i>(Check only on</i> ome 5 ☐ Reside		Accie	ted Living
ō	Physer this eral di	5. To	27. Man or of Death	28a. Date of Injury	28b. T	patient 3 DOA		ome 5 Residence 28d. Describe ho			W-04 11-12-11-5
ion	ndIng Ph tth. r: After th e funeral	ation	1 VNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Y	<i>'ear)</i> Ir		rk? Yes 2 □ No		,,		
Division or	r Attender death	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury building, etc.	- At home, far 'Specify)	m, street, factory, office		28f. Location (St. City or Town		er or Rura	l Route Number,
	spital or Al ours after d leral Direc filled in by			K							
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director, p	edical	29a. Certifier (Check only one) 1 ✓ Certifying Physical Examine 2 ✓ Medical Examine	clan: To the best of a er: On the basis of ea and manner state	camination and	death occurred at the tide of the didentification of the didentifica	me, date and place, opinion, death occui	and due to the ca red at the time, d	ause(s) and ma ate and place, a	inner as s and due to	tated. the ceuse(s)
	To th within To th comp	Me	29b. Signature and title of pertifier	M.		29c. Licens		29	9d. Date signed	(Month,	Day, Year)
			1 B- Veller	25		1) . 3	0469		1ay 4	15	2007
	10		30. Name and address of person who com	pleted cause of deal	th (Item 23a) (Type, Print) PARKWAY,	#308, C	Columbi	A, MI	0.2	1045

Registrar

31. Date filed (Month, Day, Year) MAY 0 8 2007

2. Registrar's Signature Goste

State

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2007 **Physician** 12:45 P M May 3, Angela Manley McArdle /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery 3505 Windsor Place Chevy Chase 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 🖫 F Yrs. 1925 Maryland 219-14-7123 Dec. Director 81 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show notified at 1 Yes 2 No Director Maryland | Montgomery Chevy Chase 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number be i United States 20815 3505 Windsor Place "natural", or items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 2 3 Nidowed 4 Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within the and Mental Hygiene.
7 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vera Brooks John Manley ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) mit. Pages 1 and 2 so cartment of Health an cortant: If item 27 is 1/1 injury or other traun 3505 Windsor Place, Chevy Chase, MD 20815 Mary Murray McArdle / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition May 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or Bethesda, Maryland 4 □ Donation 5 □ Other (Specify) Montgomery Crematorium, Inc. 2007 21. Signature of Funeral Service icense RODERT A. Pumphrey Pumeral Home/Bethesda—Chevy Chase, Inc. 7557 Wisconsin Ave., Bethesda, MD 20814-3501 M00896 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death 6 weeks Immediate Cause (Final disease or condition resulting in death) **Physician** Brain Cancer, Primary /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-transit law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical as attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death 5 Other (specify) P.O. cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed certificate 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 1 ☐ Yes 2 점 No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier within 24 hou

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completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier May 4, 2007 D40216 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7625 Wisconsin Ave., #101, Bethesda, Maryland 20814 Dennis A. Cullen, M.D.,

State Registrar 31. Date filed (Month, Day, Year)

MAY 0 8 2007

32. Registrar's Signature

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DHMH 17 Rev 1/2001

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Physiciar /Medica Examine	n al	1. Decedent's Name (First, Middle, Las Howard Sta. Facility Name (If not institution, give	street and number	Mana				Location of		2. Date of De Month May	Day 5	County of I		3. Time of Deat
Funeral Director		5. Social Security Number 6. St 262-62-3551	ledica) XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	CPn age (In yrs.	last birthday) 65 Yrs.	If Under Months		If Under 2 Hours		8. Date of Bir (Month, Da 08/30/1	th ly, Ye <i>ar)</i> 941	9.		ace (State or Fore try) NY
e Maryland	.	Usual Residence of Decedent 10a. State 10b. County MD		10c. Ci	ty, Town or Lo		Balti	nore			•		10	0d. Inside City Lim
3a or 28	I Dire	10e. Street and Number 6 East Read Street;	Apt. 500			10f. Zip	Code	21202			10g. Citi	izen of Wha USA	t Coun	try?
urs a	by Fur	11. Marital Status 1 □ Never Married 2X Married 3 □ Widowed 4 □ Divorced	12. Was Deceder Armed Forces 1 Yes 2 If Yes, Give Year or Dates	6?] No		Was Decedif Yes, spe-		spanic Orig n, Mexican, Specify:	in? (Spe Puerto F	cify Yes or No Rican, etc.)	F	14. Race - A Black, V SpecifyWh	White,	
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t and 2 sho Health and tem 27 is mu		19a. Informant's Name/Relationship (7 Kristin F. Choquette		100	6 Ea	st REa	d STre	eet Ap	t. 50	Route Numb O; Balti	more,	, MD 2	1202	
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been signed by should be detac	ò	Part II. Other significant conditions or	ontributing to death but not resulting in the underlying				ause give	n in Part I.			obacco u Yes 2[te to th	e cause of death
is certificate has be director, page 2 should be a short of the short	Completed							24a. Was an autopsy performed? 1 Yes 2 No		24b. Were autopsy findings available prior to completion of cause death? 1 Yes 2 No				
To the nospital or Attending Priysician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director;	atlon: To Be	25. Was case referred to medical examiner? 1 Yes	ER/Dutpatier 28b. Time of Injury		8c. Injury Work	r: 4□ Nur	sing Hon		r one) sidence 6 □Other (Specify) a how injury occurred)		
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ne Hosp in 24 hou he Fune pletely fi	edical	29a. Certifier Certifying Phone (Check only one)	vsicien: To the besiner: On the basis and manner:	of examina	owledge, death ation and/or in	n occurred vestigation	at the tim , in my op	e, date and inion, death	place, a occurre	and due to the ed at the time,	cause(s) date and	and manne I place, and	r as sta due to	ated. the cause(s)
Within Comp.	Σ	29b. Signature and title of certifier	M.D.	dest "		4417	6436	number	۲۷.			e signed (M		
.5)		30. Name and address of person who of STK HUR M.F.	. 10	V. 60	eene s	Stiee.	+ B	altin	nose	MO	21	201		
State Registra	e	31. Date filed (Month, Day, Year) MAY 0 8 200	32. Regis	trar's Sign	dture	le)								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** David William Ness, Jr. 2007 May 8:30 p^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore 3129 Bero Road Lansdowne 8. Date of Birth (Month, Day, Year Aug. 13, 1 If Under 24 Hrs. Hours Min. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 212-56-4568 1**∑** M 2□ F Months 56 1950 Director Maryland Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

Em 27 is marked other than "natural", or items 23a or 28a-f show ther traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits MD Baltimore 1 ☐ Yes 2 ☐ No Director Lansdowne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3129 Bero Road 21227 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify þ Specify: 3 ☐ Widowed 4 ☐ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Warehouse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) David William Ness, Sr. Mary Witzler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tracey Ness/Wife item 27 I 3129 Bero Road Baltimore, Maryland 21227 20a. Method of Disposition 20b. Place of Disposition (Name of Date permit. Pages 1
Department of He
Important: If iten
any Injury or oth 20c. Location - City or Town, State West Arundel Crematory 05-08-2007 Odenton, Maryland 1 ☐ Burial 2 X Cremation 3 ☐ Rem pval from State Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Line Ambrose Funeral Home, Inc. 328 Sulphur Spring Road Arbutus MD 21227 23a. Part. Enter the disease or complications that edused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final HEPATOMA Physician METASTATIC MONTHS disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed g physician and as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending | | for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 1☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 2**0**No 1 ☐ Yes P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □Other (Specify) funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: To the Funeral Director; After completely filled in by the funera Vatural or Attending 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

To the Hospital within 24 hours

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or Vital Records,

3altimore, Maryland 21215-0036

State

Registrar DHMH 17 Rev 1/2001 29d. Date signed (Month, Day, Year)

BALTIMORE

and manner stated

and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day,

mD

trar's Signature

			For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	ertificate of I		, ,	lene eg. No. 🤈 🎵	0.7	11,790
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4	/Medic		Norma	J	N e	wton		May		Year 007	11:10A M
	Examin	er	4a. Facility Name (If not institution, give				r Location of Death		4c. County o		1-1
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	Director		220-10-4001]м 2ЙБ	81 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Dec. 25	, 1925	Coum	MD MD
	/land ow at		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10	0d. Inside City Limits
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/lar	should be tand Mental Is marked oumatic eve	To E	William Henry Ros	ss			Elizabe	th Marie	Kaiser		
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	1 and Health em 27 ther tr		Mrs. Linda McCarti 20a. Method of Disposition	ney/Daught		Ardor Drive osition (Name of ematory or other place	ve Glen B		ID 21061 20c. Location - C	ity or To	wn State
nor			1 ∏ Burial 2 ☐ Cremation 3 ☐ I		1	ematory or other place Ldge Mem. F	inay	9,	Elkridge	•	
Baltimore,	permit. Pages 1 and Department of Health Important: if Item 27 any injury or other tr once.		21. Signature of Funeral Service Licens			22. Name and Addre		• .			
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>	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only commediate Cause (Final disease or condition resulting in death)	ne cause on each lir a. CHRcM	ne.	TWCTA	-			4 5₹	Approximate Interval Between Onset and Death
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Š	Physician: this certific ral director,	To Be	examiner?	Hospital: 1 ☐ Inpatie	nt 2 ☐ ER/Outpatio	ent 3 DOA Oth	Or.	th (Check only on ome 5 Reside		r (Specify	*)
n 0	ding Physician: The n. After this certificate hi funeral director, page		27. Manner of Death 1 Manual 5 □ Pending	28a. Date of Inju (Month, Day		Wor		28d. Describe ho			/
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Divi	after of Direct of in by	Certification:	4 Homicide determined	building, etc	c. (Specify)	treet, factory, office		28f. Location (St City or Town	reet and Number n, State)	r or Hura	Houte Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	edical C	29a. Certifier (Check only one) 1	sician: To the best of iner: On the basis of and manner sta	of my knowledge, dea f examination and/or ated.	ath occurred at the tin	me, date and place, opinion, death occu	, and due to the corred at the time, d	ause(s) and mar ate and place, a	ner as st	ated. the cause(s)
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	5		30. Name and address of person who c		- · · · /		Done	Grea	Rio.	tr .	42106/
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			State of Maryland / Dep State of Maryland / Dep Registrer Ce	artment of Health and Me	ental Hygie Reg.	bu W U /	14791
	A. C.		Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
П	Physici /Medic		Sandra Elaine Nowlin	A		0 2007	14:05 M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat	ו
4.0			Prince George's Hospital	Cheverly		Prince Ge	
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday 35 Yrs.	If Under 1 Year ff Under 24 Hrs. Months Days Hours Min. J	8. Date of Birth (Month, Day, Ye une 29 1	9. Birti 971 Wash	nplace (State or Foreign untry) ington DC
	and and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation			10d. fnside City Limits
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	r 28a	je C	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Co	untry?
	h with	aiD	2900 Brightseat Road # 202	20703		USA	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene important: If Item 27 is marked other than "natural", or Itama 23a or 28a-f ehow appringing or other traumatic event, the Medical Examinat must be multiled at ance.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R 1 ☐ Yes 2 ☒ No Specify:	ify Yes or No- lican, etc.)	14. Race - Ame Black, White Specify: Bla	e, etc.
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pu	be fill Hall H	Be	17. Father's Name (First, Middle, Last) James R. Nowlin	18. Mother's Name (den Sumame)	
Z	d Mer d Mer nark	10		Linda L.		h. as Taum Chata 3	in Code)
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Baltimore,	Pages 1 lent of H nt: If Iter ry or oth		1 X Burial 2 Gremation 3 Hemoval from State	osition (Name of matory or other place) 11 Cemetery 5/10/		Location - City or in the control of	
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y) .	100		23a. Part1. Enter the disea e, o complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac or	respiratory arrest,		Approximate Interval Between
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ixixi	To the Hospital or Attending Physician: The law within 24 hours effect death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification	2 Accident investigation 3 Suicide 6 Could not be determined elemined value for some street investigation investigation and some street investigation and so		8f. Location (Stree City or Town, S	t and Number or Ru tate)	ral Route Number,
۵	spital o		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place, ar	nd due to the caus	e(s) and manner as	stated
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	T wit		29b. Signature and title of certifier Piler Anaval. M.D.	D-33482	290.	Toy SH	2007
	Ŋ		29b. Signature and title of certifier 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type Science Angles, M.D. 7343 A Ha 31. Date filed (Month, Day, Year) MAY 0 8 2007	no ver Parkway (Greenbe	It, Mary	land 20770
	Sta Registr	. 5.41	31. Date filed (Month, Day, Year) MAY 0 8 2007 Registrar's Signiture	uli		,,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Gloria H. Peppler 0800 PM Mai 2007 6 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Glen Baltimore Washington Medical If Under 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** Days 1 □ M 2 ☑ F 030-14-6284 81 Director 9-15-1925 MA Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Anne Arundel Glen Burnie 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 8 Harvard Rd. 21060 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: White Completed by 3₺Widowed 4 Divorced Year or Dates: "natural", 는 Role (Baltimore, Maryland 21215-00 er than "natur , the Medical E 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygien Imporant: If item 27 Is marked other the any Injury or other traumatic event, ine ones. Administrative Assistant Allied Chemical Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George W. McLean Gladys E. Meagher 19a. Informant's Name/Relationship (Type. Print)
, Grand-19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Kimberly Fine daughter 1406 Claridge Ave., Halethorpe, MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State May 11, 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery Baltimore, MD 4 □ Donation 5 □ Other (Specify) 2007 1 Second Ave. Sw 21. Signature of uneral e a e Licensee 22. Name and Address of Facility M01411 Singleton Funeral Home; Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician NOMB /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Erner Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed and bunial-trai Due to (or as a consequence of): .O. Box 68760 Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) Division or Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No autopsy 1∏ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1

Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√ No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? To the Funeral Director: After to completely filled in by the funeral 1 Natural 2 ☐ Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MY 063726 5.6.2007.

Registrar
DHMH 17 Rev 1/2001

State

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Year)

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2007

31. Date filed (Month, Day,

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAJEKO DUNMI

Registrar's Signa

Colum

Division or Vital Records, P.O. Box 68760,

Saltimore, Maryland 21215-0036

hours after death uneral Director: within 24 hours at To the Funeral D Hospital

12

State

Registrar

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

m Julliamo Do

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cynthia M. Williams, D.O.

8

29c. License number

H0058032

6001 Muncaster Mill Road, Rockville, Maryland 20855

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** QUALLS -AVC A. 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore Towson Gilchrist Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6 - 25 - 1921 Birthplace (State or Foreign Country) 5. Social Security Number 430 – 30 – 40 6 5 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Min. Hours 1 □ M 2 X F Director 85 Oklahoma Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 'natural", or items 23a or 28a-f show Lutherville 1 ☐ Yes 2 No the Medical Examiner must be notified Maryland Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17 Ridgefield Road U.S.A. 21093 Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. filed within 72 hours after of Hygiene.
Hygiene. 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White <u>}</u> 3 ☐ Widowed 4 X Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) State of Maryland Secretary permit. Pages 1 and 2 should be filed be partment of Health and Mental Hygid Important: If item 27 is marked other any injury or other traumatic event, # 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Crocker Lottie Patton Robert James ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 17 Ridgefield Road Lutherville, MD 21093 Mary O. Smith -daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem 5-14-2007 Timonium, Maryland 4 ☐ Donation 5 ☐ 25 ner (Specify) 22. Name and Address of Facility F.H. 263 S. Conkling 21. Signature of Funeral Service Licenses Jr. Balto. MD 21224 Joseph N. Zannino 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheet, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pulmonusy **Physician** OBSMULTINE , ear LAVINIC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-trar and Due to (or as a consequence of): Division or Vital Records. P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 TVAS 2€N0 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Q63 YUCITER 1 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Stother (Specify) NOSP (1 ☐ Yes 2 ☑No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28b. Time of 27 Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 Pending investigation 12 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

State Registrar 31. Date filed (Month, Day, Year) 2007 MAY 08

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

21204

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		-	For State Registrar	State of M	laryland / D	-	ent of H ate of I		and M		giene Reg. No.	007		95
	Physici		1. Decedent's Name (First, Middle						}	2. Date of Dea Month	Day	2007	3. Time of 4:50	
	/Medic Examin	al	Shirley Jane R			4b. (City, Town, or	Location o		May	· ·	ounty of Death	4.50	A•"
	Examin	er	Manor Care-Rux	· ·		R	ossvil	le			Bal	ltimore		
	Funeral		5. Social Security Number	6. Sex 7. A	ge (In yrs. last birti 75		nder 1 Year_ ths Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Day	v, Year)	201	lace (State o	r Foreign
	Director		219-36-1866 Usual Residence of Decedent		73					March 1	L, 193		yland_	
	anylan show	_	10a. State 10b. County	imore Count	10c. City, Town y Parkvi							1	0d. Inside Ci 1 ☐ Yes	
	the M.	Director	Maryland Balt 10e. Street and Number	THOLE COULT	y rarkvi		. Zip Code				10g. Citize	n of What Coun		
	3a or	i Dir	7908 Beverly A	venue			21234					ed State		
	ams 2	Funerai	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.S.	13. Was D	ecedent of H specify Cuba	ispanic Orig	gin? (Spe n, Puerto f	cify Yes or No- Rican, etc.)	14.	Race - Americ Black, White,		
36	filed within 72 hours after death with the Maryland Hygiene. ther than neturel; or items 23s or 28e-f show ont, the Machesl Extransment be notified	by Fu	1 ☐ Never Married 2 ☐ Mar 3 ₩ Widowed 4 ☐ Divorced	If Yes Give		1 🗆 Y	es 2XXVo	Specify:			S	pecify: Wh	ite	
21215-0036	72 hou	ted	15. Deceden	t's Education st grade completed)	16a.	Decedent's	Usual Occup	ation	t of workin	na	16b. Kind	of Business/Ind	dustry	
121	Mithin 7	Completed	Elementary/Secondary (0-12)	College (1-4or	r5+) Sc		f work done o T use retired Bus Dr		,		Bali	timore (County	7
d 2	be filed within 72 ho tat Hygiene. Id other than "netur event, the Modical		12 17. Father's Name (First, Middle,	Last)		511001	DOS DI		er's Name	(First, Middle,				
/lan	should be filed within and Mental Hygiene. s marked other than umatic event, It s Mental County and	To Be	Carl Zealor					Flor	cence	Burton	l			
Maryland	2 P 2 2 2	·	19a. Informant's Name/Relations Mrs. Dawn Pell			•						o <i>wn, State, Zip</i> land 21		
	s 1 and 3 f Health Item 27 other tr		20a. Method of Disposition	etter (Daug	20b. Place of cemeter					ate		tion - City or To		
E E	Pages 1 and nent of Healti ent: If Item 23 ury or other 1		XXBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5		^e Morelar	y, crematory nd Men	or other place orial	Park	May	9,2007	Par	kville,	Maryla	ınd
Baltimore,	permit. Pages Department of Importent: If It eny Injury or o		21. Signature of Funeral Service	Licensee	1	Peace	e and Addrese eful <i>P</i> York	ss of Facilit Alterr Road	nativ timo	res Fuei	ral&Cı Marvla	remation	n Ctr. 93	,P.A.
			23a. Part1. Enter the disease, o shock, or heart failure. List	complications that cause only one cause on each	line.	not enter the	mode of dyin	ng, such as	cardiac o	r respiratory ar	rest,		Approximat Interval Bet Onset and I	te tween
	Pnysician /Marking		Immediate Cause (Final disease or condition resulting in death)	-a. CA	RCIA	VOI	7 A	0/	C	010	N			20
	/Medical Examiner		rooming in country	Due to (or a	is a consequence of	of):								
		ner	Sequentially list conditions, any, leading to in neclule cause. Enter Underlying	b. Due to (or a	as a consăquence d	of):								
	ecuted and I-transi	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or a	is a consequence o	of):								
68760,	The law requires that the death certificate be executed the sbeen signed by the attending physicien and cage 2 should be detached for use as the burial-transit	icai E		d										
89	ntificate ng phys as the		IS SEMALE.								- 1	- 1		
Вох	leath certifica attending ph d for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		2 Fetal death		oic pregnancy	/			23	d. Date of delive Month		Year
o.	that the de ed by the a detached f	ysic	1 ☐ Yes 2 → No 9 ☐ Unknown	9□ Unknown	at time of death	5 🗆 Otne	r (specify) _							
Δ.	res that igned b be deta	by Pt	Part II. Other significant conditi	ons contributing to death	but not resulting in	the underly	ing cause giv	en in Part I.	l.	23e. Did to	obacco use	contribute to the	Δ.	
ord	w require been sig should b									10	Yes 2□			Inknown
Records,	has by	Completed								24a. Was autor perfo		death?	mpletion of c	available ause of
Vital		e Co	25. Was case referred to medical	d .				26 Place	a of Death	1 ☐ Yes	21 X No	1 ☐ Yes	2□ No	
ίV	Physicien: this certificatal director,	To B	examiner? 1 □ Yes 2 No	Hospital: 1 ☐ Inpa	itient 2 ER/Ou	tpatient 3[DOA Oth	40.00		and the same of th		Other (Specif	y)	
on of			27. Manner of Death 1 XNatural 5 ☐ Pendi		njury 28b. T Day Year) II	Time of njury M	28c. İnjur War	yaf rk? Yes 2. □		28d. Describe I	now injury o	occurred		
Division	Attending r death. ector: After by the fune	Certification;	3 ☐ Suicide 6 ☐ Could	nined 286. Place of I	Injury - At home, fa			.00 20		28f. Location (S		Number or Rura	al Route Num	nber,
Ö	s after el Direct	Cert	4 ☐ Homicide	building,	etc. (Specify)					City of Tol	wii, Sialej			1
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	Medicai	29a. Certifier 1 Certifyi (Check only one) 2 Medical	ng Physician: To the be Examiner: On the basis and manner	of examination an	dor investig	irred at the tir ation, in my o	me, date an opinion, dea	nd place, a ath occurr	and due to the ed at the time,	cause(s) ar date and p	nd manner as s lace, and due to	tated. the cause(s	5)
	o the o the omple	Med					29c. Licens	se number		_	29d. Date	signed (Month,	Day, Year)	
	/		>/////Ce	24lodin			2-0	0/2	284	19	5	-6-6	27	
	Ç		30. Name and address of person	who completed cause o	f death (Item 23a)	(Type, Print)	0 0	540	-R	Dr.	Pone	SON.	102	1204
	Sta Regist	ate	31. Date filed (Month, Day, Fear	2007 32. Regis	strar's Signature	borte	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death RAIMONT **Physician** ENE 246 PM 2007 06 /Medical 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death 4c. County of Death Examiner John Hopkins Baltimore
If Under 1 Year | If Under 24 Firs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🔀 F 218-46-4215 Director 58 Oct.24,1948 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show at a or 28a-f shot be notified a MD 1 ☐ Yes 2 XNo Baltimore Directo Hydes 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4719 Hydes Road "natural", or items 23a 21082 USA permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23: any Injury or other traumatic event, the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 3altimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Equity Realty Realtor 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Dodge Rita Mae Ewing 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sal Raimond-spouse 4719 Hydes Road-Hydes, Maryland 21082 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 3 □Removal from State Gardens Of Faith Rosedale, Maryland Cemetery 22. Name 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
EVANS FUNERAL
AND CREMATION 8800 Harford Road Parkville,MD 21234 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** UIMONARY HOUR /Medical Due to (or as a consequence of) Examiner MEDIC FCUTE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner that the death certificate be executed burial-transit SUDD-DEEKS Due to (or as a consequence of): P.O. Box 68760, ng physician as the burial Physician/Medical ed by the attending detached for use as IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 █ No Month 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. 2 icate has been sig ; page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy perform funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2□ No 2 ER/Outpatient 3 DOA ို 1 Inpatient After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation (Month, Day Year) Iniury 1 ☐ Yes 2 ☐ No death. 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) MD

State Registrar 31. Date filed (Month, Day, Year)

m

600 NORTH WOLFE STREET, BALTIMORE

21287

MARYLAND

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

APOSTOLIDES

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Maryland / Dep <i>Ce</i>	ertificate of De		Reg. No	0007	11.707
	III.		Decedent's Name (First, Middle, Last)				of Death		3. Time of Death
40	Physicia /Medic		Shirley Josephine	Richardson		M	ay 5,	2007	9:15p ^M
ja	Examin	er	4a. Facility Name (If not institution, give st		4b. City, Town, or Lo		40	c. County of Death Howard	
	Funeral		5932 Old Washingto 5. Social Security Number 6. Sex	7. Age (In yrs. last birthday) If Under 1 Year	J	of Birth h, Day, Year		place (State or Foreign
В	Director		224-44-7986 ^{1□}	M 2X F 71 Yrs.	Months Days	Hours Min. (Mont)	17/193	35 V	irginia
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation				10d. Inside City Limits
	Maryl -f sho fied a	tor	MD Howar	d Elkr	ridge				1 ☐ Yes 2¶ No
	th the or 28a e noti	Director	10e. Street and Number		10f. Zip Code		10g. C	itizen of What Cou	ntry?
	s 23a	ral	5932 Old Washingto		21075			JSA 14. Race - Ameri	oan Indian
	ter de items iner m	Funeral	11. Marital Status 1 □ Never Married 2 ▼ Married	2. Was Decedent Ever in U.S. 13. Armed Forces? 1 ☐ Yes 2 No		anic Origin? (Specify Yes Mexican, Puerto Rican, et	or No- c.)	Black, White,	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. Uther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	by	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes ② No If Yes, Give · Year or Dates:	1 ☐ Yes 2 😾 No	Specify:		Specify: Wh	ite
5-0	"natu	Completed	15. Decedent's Educa (Specify only highest grade	ation 16a. Dece completed) (Given	edent's Usual Occupation e kind of work done durn DO NOT use retired)	on ring most of working	16b. I	Kind of Business/In	dustry
121	within iene. than the Me	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)	nemaker			wn Home	
br	e filed al Hyg other vent, I	Be C	17. Father's Name (First, Middle, Last)		18	8. Mother's Name (First, M	iddle, Maide	п Surпате)	
ylar	ould b Menta arked atic e	To	Leonard Wilson			Maude Ada			
Maryland	d 2 sh th and 7 is m traum		19a. Informant's Name/Relationship (Typ William Richardson		- ·	d Number or Rural Route I ngton Rd., E			0 Code) 1075
	s 1 and f Healt item 2 other		20a. Method of Disposition	20b. Place of Disp	osition (Name of ematory or other place)			ocation - City or T	
m 0	Page nent o int: If iry or		1 ⊠ Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (<i>Specify</i>)			k 5/8/2007	E	lkridge,	Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service License			of Facility fman Funeral gton Blvd.,			Inc. 21075
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death. Do not en	nter the mode of dying,	such as cardiac or respira	ory arrest,	ige, ind	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	METASTATIC BE					Onset and Death 7 YGARS
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):					
		ē	Sequentially list conditions, if any, cause. Enter Underlying	Due to (or as a consequence of):					
W	cuted nd transit	Examiner	that initiated events						
68760,	ificate be executed g physician and as the burial-transit		resulting in death) Last	Due to (or as a consequence of):					
687	ificate g physi as the l	edical	d.						
Box	h certi ending use a		23b. was decedent pregnant	ic. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3	□Ectopic pregnancy			23d. Date of deliv	
O. H	The law requires that the death certif tte has been signed by the attending page 2 should be detached for use a	Physician/M	in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		Other (specify)			Month	Day Year
P.O.	that the ed by detacl		Part II. Other significant conditions conf	tributing to death but not resulting in the	underlying cause given	in Part I. 23e.	Did tobacco	use contribute to	the cause of death?
rds	quires in sign uld be	Completed by	OSTECPCROSIS				1 Yes	2XNo 3□ Pro	bably 4 □Unknown
900	g & C	plet	RHEUMATOID A	NTHRITIS		24a.	Was an autopsy	24b. Were aut	opsy findings available ompletion of cause of
al R		Con				1_	performed? Yes 2	death?	2 X No
Vit	or Attending Physician: Thatier death. Director: After this certificate in by the funeral director, pag	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	ospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	Othor	26. Place of Death (Check		0 Dother (Co.s.	L. XI
0	g Phy er this eral d	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury a	4 Nursing Home 5 xat 28d. Des		ury occurred	19)
sior	tendin eath. or: Af the fur	atio	1) Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		M 1 ☐ Ye	es 2 No			
Division or Vital Records,	or At after d Direct in by	Certification:	4 ☐ Homicide determined	28e. Place of injury - At home, farm, s building, etc. (Specify)	treet, factory, office		tion (Street a or Town, Sta	and Number or Rui te)	al Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	a C	29a. Certifier 1 Certifying Phys	ician: To the best of my knowledge, dea	ath occurred at the time	, date and place, and due	to the cause	s) and manner as	stated.
	the Ho nin 24 the Fu	Medical	one)	er: On the basis of examination and/or and manner stated.					
	5 time 5 Loo	2	29b. Signature and title of certifier	Mrs.	29c. License n		29d. D	ate signed (Month	/
7	^		30. Name and address of person who cor			2832		03/07/	2007
_	3		SOON JA Kim, M.	8. 5808 MAIN		ELKRIDGE ,	MO	21075	
	Sta Registr		31. Date filed (Month, Day, Year)	32 Registrar's Signature					

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 05 10:33 KENNARA 2007 TAYLOR /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE N/A UNIVERSITY OF MARYLAND MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 215-77-5444 Hours 1 □ M 2 🕠 Director NOV 18 2004 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at 1 Pres 2 No Director MD 13a 1 timore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Coleherne 21229 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cubap, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. AFrican permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Ite any injury or other traumatte event, the Medical Examines 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ American 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ Kennan nni 19a. Informant's Name/Relationship (Type. Prio 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Road Coleherne mother 4625 Baltimore MD 21229 ennille Gilliam 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 5/10/07 Mt. Zion 4 Donation 5 Other (Specify) 22. Name and Address of Facility 10se Funeral Service P.A. 21. Signature of Funeral Service License Roa O Baltimone MD Z1206 Belown 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Renal Acute Failure /Medical Due to (or as a consequence of): Examiner Hyperkeleme
Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner been signed by the attending physician and should be detached for use as the burial-transit bronie Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Month Year Dav 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 ☐ No 1 ☐ Yes 2□No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice 25. Was case referred to medical Be 26. Place of Death (Check only one, Other: 1 ☐ Yes 2 No 1 🗷 Inpatient 2 ☐ ER/Outpatient ۵ 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated.

State Registrar 31. Date filed (Month, Day, Year) MAY 08 2007

29b. Signature and title of certifie

NADEEM



harrun

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A. HASHMI,



29c. License number

1518097989

29d. Date signed (Month, Day, Year)

MAY 05, 2007

			For	State of Marylar				Mental Hy	giene	
			State Registrar		Cei	tificate of	Death		Reg. No. 2	7 14799
	Physici /Medic		Decedent's Name (First, Middle, La MARGARET	ROSE ROUCHAR	D			2. Date of Dea Month May	7, ^{Day} 2007 Year	3. Time of Death 5:50A M
	Examir	er	4a. Facility Name (If not institution, giv				r Location of Dea	th	4c. County of De	
			Stella Maris Hos 5. Social Security Number 6. 8	·	last birthday)	Timoni If Under 1 Year	UIII If Under 24 Hrs	8. Date of Birt	Balti	
	Funeral Director		722-18-6241	¹□ ^M ² XX 82	Yrs.	Months Days	Hours Min	August 1	7,1924 Mar	irthplace (State or Foreign Couptry) 'Yland
	and ww		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				10d, Inside City Limits
	death with the Maryland ms 23a or 28a-f show r must be notified at	tor	Maryland Baltimo	re Tim	onium					1 □Yes 2.□No
	th the or 28a e noti	Directo	10e. Street and Number	,		10f. Zip Code			10g. Citizen of What 0	Country?
	ath wi	ral	106 Castletown Ro			2109			USA	
	ter de Items Iner m	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in L Armed Forces?	J.S. 13.	Was Decedent of H f Yes, specify Cub	lispanic Origin? (an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		nite, etc.
0 a.m. 21215-0036	filed within 72 hours after Hygiene. other than "natural", or Ite ent, the Medicai Examine	by	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 □ Yes XX No	Specify:		Specify: W	ite
5-0	172 hc "natu edicai	etec	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Deced	lent's Usual Occup kind of work done DO NOT use retired	oation during most of we	orking	16b. Kind of Busines	s/Industry
a 2	withir iene. than the Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		emaker	шу		0wn Ho	ome
5:50 land 2	be filed ital Hyg id other event,	Be C	17. Father's Name (First, Middle, Last	,			1.1	, , ,	Maiden Surname)	
yan Yan	should b ind Ment marked umatic e	T ₀	Frank Conrad Brau		T			Gibmeyer		
7 Mar	d2sh thand t7 Isrr traum		19a. Informant's Name/Relationship (John Craig Lurz	(Type. Print) Son)	•			er, City or Town, State Maryland 2	, ,
2007 re, M	s 1 ar if Hea item 2		20a. Method of Disposition	20b.	Place of Dispo	sition (Name of natory or other place	1	Date	20c. Location - City	
, m	Pages ment of I ant: If ite ury or o		XX Burial 2 □ Cremation 3 □ ↑□ Donation 5 □ Other (Speci	Removal from State		ley Memoria		5/11/07	Timonium,	Maryland
MAY 7, 2007 Baltimore, Mary	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21/ signature of Funeral Service Lice	n Kenaku					xdefeld Funer imore, Mar	al Home Inc Tyland 21212
			23a. Part1. Enter the disea e, or con shock, or heart failure. List only	nplications that caused the dea	th. Do not ent	er the mode of dyir	ng, such as cardia	ac or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a BREAST CANO						Onset and Death
	Examiner			Due to (or as a conse	quence of):					
1		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conse	quence of):					
J	ecuted and -transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a conse	quence of):					
68760,	ficate be executed physician and the burial-transit	alE			4401100 01)1					
	tificate ng phy as the	Medical		- u.						
Вох	ath certi ttending or use a	an/In	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pregr 1 ☐ Live birth 2 ☐ Fet	al death 3	Ectopic pregnanc	у		23d. Date of d	lelivery Day Year
0	nat the dead by the all etached for	Physician/M	1 ☐ Yes 2 XNo 9 ☐ Unknown	4⊡Pregnant at time of 9⊡Unknown	death 5□	Other (specify) _			Working	<i>Duy</i>
ر. ح.	s that ined by	by Ph	Part II. Other significant conditions	contributing to death but not re-	sulting in the u	nderlying cause giv	en in Part I.	23e. Did to	obacco use contribute	to the cause of death?
MARGARET ROUCHARD ision or Vital Records	requires een sign nould be		_					1 🗆 '	Yes 2□No 3□	Probably 4 Nunknown
Sec E	e law r has be e 2 sh	Completed						24a. Was	an 24b. Were prior to death	autopsy findings available completion of cause of
ROI al F	n: The ficate har r, page		Of West and referred to modical	T				1□ Yes	2 X No 1 □ Y	
ΕŢ	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼ No	Hospital: 1 Inpatient 2]ER/Outpatier	nt 3 DOA Oth		eath <i>(Check only o</i>		pecify) HOSPICE
SAR	ng Phy fter thi		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Inju		T	how injury occurred	isony) LIGHT LOD
Sion	Attending r death. ector: After by the funer	catic	2 Accident investigation 3 Suicide 6 Could not be			M 1 □	Yes 2□No			
MARGARET ROUCHARD Division or Vital Records	al or At s after d il Direc	Certification:	4 ☐ Homicide determined			еет, тастоту, опісе		City or To	Street and Number or wn, State)	Hural Houte Number,
	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	edical (29a. Certifier (Check only one) 1X Certifying P 2 Medical Exa	hysician: To the best of my kn miner: On the basis of examin and manner stated.	owledge, deat ation and/or in	h occurred at the ti vestigation, in my	me, date and plac opinion, death oc	ce, and due to the curred at the time,	cause(s) and manner date and place, and d	as stated. lue to the cause(s)
	To the within 2 To the complete	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date signed (Mo	onth, Day, Year)
			/			104	3725		5/7/	07
	10		30. Name and address of person who	•			PTMONTIBE	WD 0100	12	
	Sta	ate	DR. TARIQ MAHMOO 31. Date filed (Month, Day, Year)	32 Registrar's Sign		estes	LICHIUM	, MD 2109	7.3	
	Regist	rar	BEAV A Q 1	7017 1 82 30,000 0	all asset	Str. Both				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, tata Amend #20a-c, perFH, g867, 5/24/07 TT Certificate of Death Rag. No.-1. Decedent's Name (First, Middle, Last) 2 Date of Death Month **Physician** Year 048 2001 /Medical 4a. Facility Name_(If not institution, give street and number) 4b. City Town, or Location of Death Examiner 4c. County of Death 1 tospital Bulltmi DOLUVIS 7. Age (In yrs. last birthday If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Oay, 08-03-**Funeral** Birthplace (State or Foreign Country) 541-20-425 Days Hours **™** M 2□ F Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. tnside City Limits or 28a-f show Cancer and Mental Hygiene.
Is marked other then "nature!", or iteme 23a comments of the Medical Examiner must be notified at 1 Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 200 ઝાઝર 00 Funeral death Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1□ Yes 2□√o Specify þ 3 Widowed Divorced Specify: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO (OT use retired) 15. Decedent's Education (Specify only highest grade completed) Unk 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Father's Name (First, Be 18. Mother's Name (First, Middle, Maiden Surnam ersch ပ္ e/Relationship (Type, Print) 19a. Informant's N 19b. Mailing Address Street and Number or Rural Route Nu Eas WA 98112 Blud. Department of Heelth Importent: If Item 27 20b. Place of Disposition cemetery, crematory
Kensico Cemet 20c. Location - City or lown, out 20a. Method of Disposition 1 X Burial ŏ 3 Removal from State 5/14/2007 4 Donation 5 Other (Specify) 21. Signature of Funeral Service bicense eny in Services Buto. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heard ailure. List only one cause on each line. Approximate Interval Between Onset and Death trmmediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Tel Securations list ou diffurs if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examine physicien and the burial-transit The law requires that the death certificate be executed Due to or as a consequence of): P.O. Box 68760 use as t *tF FEMALE* 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 \(\text{Yes} \) 2 \(\text{No} \) No 23d. Date of delivery 3 Ectopic pregnancy jo Month Dav Year 5 Other (specify) signed by the a 9☐ Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 🗌 Yes certificate has been si irector, page 2 should 2 🗆 No 3 Probably 4 Unknown 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed 2 No 1□ Yes or Attending Physician: funeral director, 25. Was case referred to redical examiner? 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2º No 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Atural 5 Pending investigation s after death. 2 Accident in by the 6 Could not be 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours af To the Funerel Di completely fitled in the Hospitel 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certific 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

30. Name ar

31. Date filed (Month, Day, Year

08

2007

500

use of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 200 7 **Physician** 5:10 AM Eugene Edward Scheufele May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Hallmark Circle Baltimore 8415 Parkville If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days 1**M** 2□ F 56 218-54-8091 January 10, 1951 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Baltimore Maryland Parkville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 8415 Hallmark 21234 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: Victory 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ZNo ģ Specify: White 3 ☐ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) traumatic event, the MAK Delivery Dairy 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce. Scheufele Gertrude Eugene ပ္ Hittel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8415 Hallmark Circle Parkville, MD 21234 Holly Scheufele / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hanover, MD 4 Donation 5 ☐ Other (Specify) Anatomy Giffs Registry May 3, 2007 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Funeral Service Licensee SUITE P Hanover, MD 21076 7522 Connelley Drive 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** moule /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, つ burial-tran Due to (or as a consequence of): physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA After this funeral 28a. Date of Injury (Month, Day Year) Manner of Ceat 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending Natural 5 Pending Injury investigation 1 Yes 2 No 2 ☐ Accident by the within 24 hours after death To the Funeral Director: 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated 29c. License number 29b. Signature and title of certi-D57703

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Franklin Sq. Dr. St. 2200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2007 ear Month Physician May 10:18 P M Geraldine Catherine Steiner /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Upper Chesapeake Medical Center Bel Air 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, FEB 28, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, **Funeral** Days Months 1 M 2 TF 77 216-24-4374 1930 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at MD Harford Abingdon 1 ☐ Yes 2 XNo Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3859 Memory Lane, Apt D 21009 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Si 등 이기 성실시 Itimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify Specify: White ò 3 Nidowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked Sadie Madden Joseph McLaughlin မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Trish Moss/Daughter 325 Newkirk St Baltimore, MD 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or o once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc 5/8/07 Baltimore, MD 21. Signature of Funeral Service Licensee C. Cremation Society of Maryland, Inc. 299 Frederick Rd Baltimore, MD 21228 Todd Dring 23a. Part1. Enter the disease, or como cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** year disease or condition resulting in death) /Medical Due to (or as a consequence **Examiner** Cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ Ho Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Nonknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 2 1 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 မှ 1 Inpatient 27. Manner Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 atural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Decritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Division of Vital Records, P.O. Box 68761 within 24 hours arter community to the Funeral Director: Aft

> State Registrar

29h. Signature an

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Registrar's Signature

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Year)

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29d. Date signed (Month, Day, Year)

S. Atwood Road

State of Maryland / Department of Health and Mental Hygiene Certificate of Death **Rep No.*** 7				Please T	ype or Prin							•	
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Physician (Medical Examiner) Physic	Ĭ	should nd Me mark maric	٦ ۲			Lan	19b. Mailin	g Address (Street				or Town, State, 2	Zip Code)
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Section Part	25	/Medical Examiner	xaminer	shock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	a conseque	eroti					ease	Onset and Death
The second of th	Box 6876	death certificate be attending physic d for use as the b	_	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, <i>o</i> utc <i>o</i> me 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal d	leath 3 🗆		y				
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Sample S	/ita	ician: sertifica ector, I	Be	evaminer?	Hoenital:			Oth		ath (Check onl	y one)		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Sharon McCormack, M.D., 5411 Old Frederick RD, Suite 18, Baltimore, MD 21229	on or	ding Phys h. After this funeral dir		27. Manner of Death 1 XNatural 5 Pending	28a. Date of Injul	ry 2	28b. Time <i>o</i> f	28c. Inju	y at k?	T			cify)
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Sharon McCormack, M.D., 5411 Old Frederick RD, Suite 18, Baltimore, MD 21229	\	North Con	Σ	29b. Signature and title of certifier	1 ha /a	1	MA			2			
Dr. Sharon McCormack, M.D., 5411 Old Frederick RD, Suite 18, Baltimore, MD 21229	,			30. Name and address of person who co	, ,,				- 7 7 0		1.80	-, 1, 200	
State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature 32. Registrar's Signature	_	4		Dr. Sharon McCorm	ack, M.D.	, 541	1 01d	Frederic	k RD, Su	ite 18,	Ba1	ltimore,	MD 21229
TELL 1 1 W 1/ mm - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1				31. Date filed (Month, Day, Year)	32. Registra	ar's Signatu	ire And	de					

			1 - For State Registrar	State of Ma		artmen rtificat			nd Mer		ene g. No. 2 (07	1480
	Physic /Medi		1. Decedent's Name (First, Middle, Last Albert G. Sam						M	Date of Death Month AY	Dav	0 ^{Yeer}	3. Time of Death 2:25 A M
	Exami	ner	4a. Facility Name (If not institution, give Harborside Healt 5. Social Security Number 6. Se	hcare	(In yrs. last birthday)		Ba1	Location of I	9	Date of Birth	4c. County	N/A	place (State or Foreign
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	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28e-f show ite Madical Examiner must ke netitied at	Director	10a. State		10c. City, Town or Lo Balti		Code			10	g. Citizen of		0d. Inside City Limits 1 X Yes 2 □ No
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9800	ours after o iral, or iten Examiner	þ	1 X Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates:		If Yes, spec		spanic Origin n, Mexican, F Specify:	Puerto Rica	in, etc.)		ck, White,	
1215-(be filed within 72 hours after death with the Maryla ital Hygiene. id other than "natural", or items 23a or 28e-f shov svent, the Mudical Examirer must ke notified at	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	life.	dent's Usua kind of wo DO NOT us CECUT	rk done d se retired,	uring most o	f working	1	6b. Kind of B	usiness/Ind	,
yland 2	12 should be filled within h and Mental Hygiene. 7 is marked other than "raumatic event, the Max	To Be C	17. Father's Name (First, Middle, Last) Robert Lee						Name (Fil	rst, Middle, M. Hay)
Baltimore, Maryland 21215-0036	s 1 and 2 should f Health and Mer Itam 27 is marks other traumatic		19a. Informant's Name/Relationship (T) Christine Lavaur, 20a. Method of Disposition		4205	Elsa	Terr	ace,#1		ltimore		y1and	21211
altimor	artment o ortsnt: If injury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licens		20b. Place of Dispo cemetery, crer Metro Cre	mator	y In	c. 05	5/08/0	07 1	Baltim	ore.	Maryland
Ä	Dermi Depa Impo any ir		Thomas Gregor 23a. Part1. Enter the disease, or compl	ications that caused th	e death. Do not ent	remat 99 Fr	lon eder of dying	SOCIÉT ick Ro	bad Ba	Maryla altimon	and, Li re, Ma:	nc. rylan	d 21228 Approximate
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	Vith Con	Σ	29b. Signature and title of certifier			29c.	License	number			d. Date signed		
4	3 1		30. Name and address of person who co	mpleted cause of deat	h (Item 23a) (Type, I	Print)		0560			1A-1 4		7
	Sta	to.	PATYKAT KI+5TERTA 31. Date filed (Month, Day, Year)	L 201, P	SACK RIVE	RN	ECIL	Rs #	109,	BALTI	MORE	1~>	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 6 per 11 2867 5-8-07 vt. State of Maryland 7 Department of Health and Mental Hygiene

		•	State Registrar		Ce	rtificate of	Death		Reg. No.	7 11 005		
*	Dhysiai		1. Decedent's Name (First, Middle, Last					2. Date of De Month	ath Day Year	3. Time of Death		
	Physicia /Medic		John Jerome Schwa	ibland		<u></u>			05/2007	7 12:12 AM		
	Examin	er	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o Baltimor	r Location of Death ◆ △		4c. County of Dea	ath		
	Funeral		5. Social Security Number 6. Se	ex 7. Age (In yrs. I	ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	th 9. Bi	rthplace (State or Foreign		
Ĕ	Director		213-03-1303	89	Yrs.	Months Days	Hours Min.	8. Date of Birl (Month, Da Mar. 2	7, 1918	Maryland		
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	ocation				10d. Inside City Limits		
	Maryl -fsho fied a	tor	MD	Bal.	timore					1 ☐Yes 2 ☐ No		
	h the	irec	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	Country?		
	th with	Funeral Director	3235 Abell Avenue	<u>, </u>		21218			USA			
	tems terms	nue	11. Marital Status	Was Decedent Ever in U. Armed Forces?		Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	14. Race - Am Black, Wh			
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by F	1 X Never Married 2 Married 3 Widowed 4 Divorced	1		1 ☐ Yes 2 🔀 No	Specify:		Specify:	white		
Baltimore, Maryland 21215-0036	"natur	Completed by	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Dece (Give	dent's Usual Occup	nation during most of world)	king	16b. Kind of Busines	s/Industry		
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lar	2 sho and I is ma		19a. Informant's Name/Relationship (7						er, City or Town, State,	, ,		
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0 U	ng Ph fter th neral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	of 28c. Inju	ry at rk?	28d. Describe	how injury occurred			
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	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C	(Check only 2 Medical Exam	ysician: To the best of my kno niner: On the basis of examina								
	To the H within 24 To the F complete	Medi	one) 29b. Signature and title of certifier	and manner stated.		29c. Licens			29d. Date signed (Mo			
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,	1		30. Name and address of person who					,	0-1-11			
Ú	+1		GIZAW WOLD			W. BEZU	EDERE	AUE,	BALTIM	ORE, MD 21219		
	, Sta Registi	_	31. Date filed (Month, Day, Year)	32. Resistrar's Signa		hart !						

			1 - For State Registrar	State of M	Maryland		irtment <i>tificate</i>			ind M	ental I		ne 0 (17	# 3rd	306
			1. Decedent's Name (First, Middle, Last)								2, Date o Month	Death	Day	Year	3. Time o	f Death
	Physici		Marian H.	Sibley							May	3,	2007	1641	7:05	5 P M
	/Medic Examin	_	4a. Facility Name (If not institution, give s		er)		4b. City, 1	Town, or	Location of	f Death			4c. County	of Death		
			Broadmead					Cock	evsvi	11e			В	alti	nore	
	Funeral		5. Social Security Number 6. Sex		Age (In yrs. las	t birthday)	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of	Birth Day, Y	ear)	9. Birthp	lace (State of	or Foreign
	Director		481-05-8820	M 2∭ F	89	Yrs.		,-			Dec.	19,	1917	I		
	pu .		Usual Residence of Decedent 10a. State 10b. County		10c. City, 7	own or Lo	cation							1	0d. Inside C	ity Limits
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	with t	ō	13801 York Road				TOI. ZIP	C008		2102	^	109	. O.((28)) O. **			
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	iten item	un-	1 Never Mamed 2 Marned	Armed Force	s?		Vas Deced f Yes, spec		n, Mexican,	Puerto	Rican, etc.)	Black	k, White,	etc.	
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21215-0036	ilied within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23s or 28s-f show year, the Medical Examiner must be natified at	Completed	15. Decedent's Educ		1		lent's Usua			of worki		16	b. Kind of Bu	siness/Ind	dustry	
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2	giene giene	Com	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	5+		Tead	cher						Educa	ation	1	
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<u>a</u>	Ment Ment arkec	2	Edward Halverson	1					Ag	nes	Mosby	7				
Maryland	2 sho and is m		19a. Informant's Name/Relationship (Type	e, Print)		19b. Mailin	g Address	(Street a	nd Numbe	r or Rura	I Route No	ımber, C	ity or Town, S	State, Zip	Code)	
≥ .	and ealth n 27 her tr		Donald Sibley/Son				nadbus		ane				en, MA			
ore	iges 1 and 2 should be filed within 72 hours after death with the Marylan to Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23e or 28a-f show or other traumatic event, the Medical Examiner must be natified at		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Re	emoval from Sta	20b. Plac	e of Dispo	sition (Nam natory or of mator	ne of ther place	9) i 1		ate 7	20	c. Location -	City or To	wn, State	
Ĕ	Pag ment ant: ury c		' 4 □ Donation 5 □ Other (Specify)		Heti					1ay 200	7		Balt:			
Baltimore,	permit. Pages 1 and Department of Heali important: If item 2 any injury or other once.		21. Signature of Funda Project Ocense	el J. F	'lagle	Len 10	Name and nmon I W. Pa	Address Funer adon:	s of Facility ral He ia Roa	ome ad T	of Du	lane	y Va1: MD 210	ley,	Inc.	
Pk.			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caus	sed the death.										Approxima Interval Be	tween
· · · · · · · · · · · · · · · · · · ·	Physician /Medical Examiner	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events		as a consequer		5	Do	Mb.	nti	0				Onset and	56411
x 68760,	death certificate be executed eathoring physician and a for use as the buriat-transit	Physician/Medicai Exa	resulting in death) Last		as a consequer					U.S. 1975		-2.00		11	21.	
O. Box		ysician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		2 ☐ Fetaf de t at time of deat	ath 3	Ectopic pre Other <i>(spe</i>					_	23d. Date Mor			Year
rds, P.	quires that the signed by all be detacted	by	Part II. Other significant conditions con	tributing to deat	h but not resultii	ng in the ur	nderlying ca	ause give	in in Part I.			oid tobac	2 DNo	ibute Io th		death? Unknown
Vital Record	The law requires that the rate has been signed by th page 2 should be detache	Completed										Mas an utopsy performe	d?	Vere autorior to coreath?	psy findings npletion of o	available cause of
ita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?						26. Place	of Death	Check o	nly one				
of <	Physician: r this certific ral director.	2	1 ☐ Yes 2 ☐ No	ospital: 1 🗌 fnp:	atient 2 EF	VOutpatien		-	4 Nul	rsing Hor	me 5□ 1	Residenc	e 6 □Othe	r (Specify	()	
ion o	ding P. After fune	ertification:	27. Manner of Death 1 Matural 5 Pending 2 Accident investigation	28a. Date of f (Month,	njury Day Year) 28	3b. Time of Injury	M 21	8c. Injury Work 1 🗆 Y	at ? ∕es 2 □ N		28d. Desci	ibe how	injury occurre	ed		
Division	or At fter d Direct on by	Certific	3 Suicide 6 Could not be determined	28e. Place of building,	Injury - At home etc. (Specify)	e, farm, str	eet, factory	, office				on (Stree r Town, S	et and Numbe State)	er or Rura	l Route Nun	nber,
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edical	29a. Certifier 1 Certifying Physical (Check only one) 2 Medical Examination		s of examination											s)
	To t To tl com	Ž	29b. Signature and title of certifier	1		1-1	290	. License	number			29d	. Date signed	(Month.	Day, Year)	
,	+		Barbara	as.	BALL	IM	6)	D:	383	90	2		5/2	1/5	2007	7
100	10		30. Name and address of person who co	4RRO	of death (Item 2)	1.D.	Print)	80	L }	IOR	RKI	RD	,000	KE	YSVI	UE,
	Sta Registi		sale and continue of the sale	Ma. De	as the	Spa										

ORIGINAL

DHMH 17 Rev 1/2001

			1. Decedent's Name (First, Middle, Last)					2. Date of Deat	th		Time of Death
	Physicia		Katherine R.	Sprucebar	nk			May	Day 20	Year	4:06 PM
	/Medic Examin		4a. Facility Name (If not institution, give s Union Memorial H	treet and number)		4b. City, Town, o	r Location of Death		4c. County	of Death	
	Funeral		Social Security Number 6. Sex	7. Age (In	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	Year)	9. Birthp	lace (State or Foreign
	Director		220-24-0794	^M ¾□xF 78	Yrs.	Months Days	Hours Min.	Nov. 10		Mary	**
	pug w	-	Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or Lo	cation				11	0d. Inside City Limits
	Maryla f sho	ō	Maryland N/A		Baltimo	re					1 x Yes 2 □ No
	the 7	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of W	hat Coun	try?
	death with the Maryland ms 23a or 28a-f show r.must be notified at	alD	3939 Roland Avenue	#308		21	211		USA		
	ems er mu	Funeral	11. Marital Status	2. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of F f Yes, specify Cub	lispanic Origin? (Span, Mexican, Puert	ecify Yes or No- Rican, etc.)		- America	
30	hours after tural", or Ite al Examine	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Midowed 4 ☐ Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:		1 □ Yes 2 🙀 No	Specify:		Specify.	Wh	ite
9500-61212	be filed within 72 hours after death with the Marylar tal Hygiene. d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	ed b	15. Decedent's Educ	cation	16a. Deced	lent's Usual Occup	pation		16b. Kind of Bu	siness/ind	lustry
ر 12	filed within 72 h I Hygiene. other than "nate ent, the Medica	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)			during most of word d)	king			
	ed wit ygien er th	Sol	8		Home	maker				1 Hom	e
בחם	be fill	Be	17. Father's Name (First, Middle, Last) Jesse Chester Har	· +				e (First, Middle, M Cherine F		,	tto
Maryiand	d 2 should be the and Mental the same of the same of traumatic every	2	19a. Informant's Name/Relationship (Typ.		19h Maiiir	a Address (Street	and Number or Ru				
<u>8</u>	d th			ghter			Street,		•		•
ō,	f Healt f Healt item 2		20a. Method of Disposition	2	Ob. Place of Dispo				20c. Location -		
Ē	Page nent o int: If	Ì	1 XXurial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	emoval from State	Baltimore			/2007 E	Baltimor	e, M	aryland
Baitimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Funeral Service License	(Wenn 1)) Bu	Name and Address Irgee-Hen	ss of Facility SS—Seitz Road, Ba	Funeral	Home, 1	nc.	21211
Н			23a. Part1. Enter the disease, or complication shock, or heart failure. List only on	cations that caused the							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition							-	Onset and Death Z day
n.	/Medical Examiner		resulting in death)	Due to (or as a co	nsequence of):	70110171					
	Examine	_	Sequentially list conditions, b	Due to (or as a cor	nceguence of					_	
ī	ist Mad	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Duo 10 (01 d3 d 001	nsequence or,						
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68/60 ,	leath certificate be executed attending physician and for use as the burial-transit	cian/Medical	C d								
	ertifica ling pl	Med	IF FEMALE:	On Marine autonome of a							
X Q Q	eath c attenc for us	ian/	in the past 12 months?	3c. If yes, outcome pf pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time	Fetal death 3	Ectopic pregnanc Other (specify)	У		23d. Date Mor	e of delive oth	ry Day Year
j.	the d	Physic	1 □ Yes 2 🗷 No 9 □ Unknown	9□Unknown	7 O. QOULT	3 Gillor (apaciny) =					
7	The law requires that the date has been signed by the bage 2 should be detached		Part II. Other significant conditions con		1	. 1		23e. Did tot	bacco use contr	ibute to th	e cause of death?
ğ	equire en siç ould b	ted t	chronic abstru	ctive by	1/wover	y dise	086	1 □ Ye	es 2□No	3 ☐ Prob	ably 4 Unknown
Records,	law r nas be e 2 sh	Completed by						24a. Was a autops	sv n	rior to cor	psy findings available npletion of cause of
		Sol						1 Yes		eath? □Yes	2 No
VITal	slclar certif rectoi	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	ospital:	OF FRONTS A	t 3D DOA Oth	or.	th (Check only on			
Ö	y Phy er this eral di	T: To	1 Yes 2 No	28a. Date of Injury	2 ER/Outpatier 28b. Time o	I JU DOX	4 LI Nursing H	ome 5 Reside			/)
0	ath. rr: Afte	ation	1 Natural 5 □ Pending 2 □ Accident investigation	(Month, Day Yea	ar) Injury		Yes 2∐No				
UIVISION	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director, i	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - building, etc. (S	At home, farm, str pecify)	eet, factory, office		28f. Location (St City or Town		er or Rura	l Route Number,
_	spital ours a neral [29a. Certifier 1 Certifying Phys	ician: To the best of my	v knowledge, deat	occurred at the ti	me, date and place	and due to the c	ause(s) and ma	nner as si	ated
	ne Hos n 24 hr ne Fur pletely	edical	(Check only 2 Medical Examination)	ner: On the basis of exa and manner stated.	imination and/or in	vestigation, in my	opinion, death occu	rred at the time, d	late and place,	and due to	the cause(s)
	To the To the Comp	Ž	29b. Signature and title of certifier			29c. Licens	se number	2	9d. Date signed	(Month,	Day, Year)
	7		Vely D. to	J.M cin	١.	ATZ	243892	16	May	4,2	007
	10		30. Name and address of person who co	mpleted cause of death	Unia	n Moma	rial H	spirtal	M		
its.	Sta		31. Date filed (Month, Day, Year)	32. Régistrar's S	Signature	berli					
	Registr	ar	MAY 0 8 2	JUI ALLENGE	1 /2 6	1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 000 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 4, 2007 Year **Physician** 9.45AM May Young Soh Chi /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Ellicott City Health and Rehab Ellicott City Howard If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 □ F 91 Feb 2,1916 Director South Korea 212 02 5713 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h, County пs 23a or 28a-f show must be notified at 1 Yes 2 No MD Ellicott City Director Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21043 USA 3000 N. Ridge Rd. Funeral 7 is marked other than "natural", or items traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No Specify þ Specify: Asian 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) N/A College (1-4or 5+) N/A N/A N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown Unknown 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3912 Pall Mill Rd. Ellicott City, MD 21042 Byung Chae Soh/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley
Memorial Gardens Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) May 7, 2007 Timonium, MD 21. Signature Fragile Milhael J. Flagle 22. Name and Address of Facility
Lemmon Funeral Home Of Delaney Valley Inc.
10 West Padonia Rd. Timonium, MD 21093 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Ballbladder Immediate Cause (Final **Physician** arcinoma disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence offs Physician/Medical Examiner The law requires that the death certificate be executed burial-tra Due to (or as a consequence of). attending physician the use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 1 Yes 2 No 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of page 2 s death? 1 ☐ Yes 2 ☐ No. certificate Certification: To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Leath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: filled in by the after death within 24 hours a

To the Funeral I

completely filled

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Ramesh Sabapaphi, M.D. 201 Backriverneck Road Suite 109 Essex, MD 21221

31. Date filed (Month, Day, Year) State

32. egistrar's Signature

Registrar

Medical

		1 = For State Registrar		Maryland / Dep Ce		lealth and	Mental Hygi		7 14809
	74	1. Decedent's Name (First, Middle, Las	t)				2. Date of Death	1	3. Time of Death
Physic		1	Trank Wil	son Suydam			Month	4, 2007	6:00 AM M
/Med Exami		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of De		4c. County of	
		Wilson Healt	h Care (enter	Gai	thersb	iro	M	lontgomery
Funeral		5. Social Security Number 6. Se		Age (In yrs. last birthday		If Under 24 H	Irs. 8. Date of Birth	Year) S	Birthplace (State or Foreign Country)
Director		201-03-6743	ALM 2UF	88 Yrs.	William Bayo	110010	March 27		New Jersey
pu *	7	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
anyla eho	7			Too. Oxy, Town of E					1 ☐ Yes 2 🛣 No
he N	Director	Pennsylvania Northam	pton	<u> </u>	1	<u>ethlehe</u>		D. Oliforn of 14%	
IC ID-UUSO within 72 hours after death with the Maryland ane then "natural", or items 23a or 28a-1 show we Madical Exercites Trust to notified at		10e. Street and Number			10f. Zip Code		10	g. Citizen of Wh	
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iter d	in.	11. Marital Status 1 □ Never Married 2 ☒ Married	Armed Force	s?	If Yes, specify Cuba	an, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)		White, etc.
is af	by	3 Widowed 4 Divorced	If Yes, Give Year or Date:		1 ☐ Yes 2 No	Specify:		Specify:	libit o
ture to	Pe	15. Decedent's Edi		16a, Dece	dent's Usual Occup	ation		6b. Kind of Busin	White ness/industry
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aryic should and Mer sumaric	-	19a. Informant's Name/Relationship (T	ype, Print)	19b. Mail	ing Address (Street	and Number or	Rural Route Number,		
C = 14 F		Alice Suydam/ W	life	445	5 Steuber	Road I	Bethlehem.	Pennsy1	vania 18020
S 1 and 3 Health itam 27 other tr		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or cemetery, crematory or other place)							
Darrimore, permit. Pages 1 ar Depertment of Hear important: if item any injury or othe		1 ☐ Burial 2 Ma Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify)		Mon Cremat	tgómery orium Inc	4	May 2007	Retherd	a, Maryland
DORLIFTING permit. Pag Depertment important: I any injury o	1	21. Signature of Funeral Service Licens	iee ,			ss of Facility R	bert A. Pu	mphrey	Funeral Home
Deperiment of the periment of	1	1 1/2 77	1/1	M00335 Be	thesda-Ch	nevy Cha	se Inc.	7557 Wis	Funeral Home/ consin Avenue
· 3	3	23a. Part1. Enter the disease, scoomd shock, or heart failure. List only of	lications that causine cause on each	ed the death. Do not en line.	ter the mode of dyir	ng, such as card	fiac or respiratory arre	st,	Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition resulting in death)	a Hoc	ite car	mar	ysyp	rdrom	e_	5 min.
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√ p ₀ is	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	C d a	as a consequence or):	417-1				
and I-tran	хап	that initiated events resulting in death) Last	C. Due to (or a	as a consequence of):	ne	y con	car		
te be executed ysicien and le burial-transit	calE		200 (0) (0)	25 a 55/155 q 56/15 q 57/1.	V				
> 0	_	•	d						
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Bath cert attending for use a	lan	in the past 12 months?	1☐Live birth	2 Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)	′		23d. Date of Month	
the d	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown		Other (specify)				
that the ded by	Ph	Part II. Dther significant conditions co	ntributing to death	but not resulting in the u	inderlying cause giv	en in Part I.	, 23e. Did toba	acco use contribi	ute to the cause of death?
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he law requires to has been signed age 2 should be company.	ete			nemia				045 14/-	
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n: Th		artase, ch	ime	eympho.	eytee &	euken	CLL 1 Yes 2	1 No 1	Yes 2□No
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or Attending Physicien: The far after death Director: After this certificate has in by the funeral director, page 2	5	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Ir	itient 2 EP/Outpatie	nt 3 DOA	4 Nursing	Home 5 Resider		
ding the file	tion	1 ☑Natural 5 ☐ Pending	(Month, I	Day Year) Injury	Wor	k? Yes 2 □No	200.000.00	. Injury coodinoc	
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after Dire	erti	4 Homicide	building,	etc. (Specify)			City or Town,	State)	,
To the Hospital or Attant within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Phy	rsician: To the be	st of my knowledge, dea	th occurred at the fir	ne, date and pla	ace, and due to the car	use(s) and mann	er as stated.
• Ho 24 h • Fui	Medical	(Check only 2 Medical Exam one)	iner: On the basis and manner	of examination and/or in	nvestigation, in my o	pinion, death of	ccurred at the time, da	te and place, and	d due to the cause(s)
To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Licens	e number	29	d. Date signed (Month, Day, Year)
F > P* 0		N. Robert 5	18 1-11	Idea - Vi	in Do	411.5	- /	Mars 4	1,2007
r l. i		30. Name and address of person who c		100	Print) 200	PI	SSELL AVERSBURG	office	1000
14+1		1.1. RUBERT BI	RSCH#	BACH MIN	GA	17 HS	RSBURG	MILL O	20847
St	ate	31. Date filed (Month, Day, Year)	32 Regis			_			
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		For State of Man		artment of Hea ertificate of De			ne 200	7 14810
Dhusia		1. Decedent's Name (First, Middle, Last)	~	_		2. Date of Death Month	Day Ye	3. Time of Death
Physici /Medi		EDWIN HARVEY STEWAR	r, Jr.,M.		(5 1)	MAY	6 20c	7 9:10 AM
Examir	ner	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Loc			4c. County of E	N/A
Funeral			In yrs. last birthday)		Under 24 Hrs.	8. Date of Birth (Month, Day, Y	9.	Birthplace (State or Foreign Country)
Director		214-22-7496 ^{1万 № 2□ F}	90 Yrs.	Months Days H	lours Min.			Maryland
and land		Usual Residence of Decedent 10a. State 10b. County 1	0c. City, Town or Lo	ocation				10d. Inside City Limits
Maryla Maryla a-f sho	tor	Maryland N/A	Balti	more City				1 XYes 2 ☐ No
lo/// with the Ba or 28a the noti	Director	10e. Street and Number		10f. Zip Code		10g	. Citizen of Wha	
ath wi		302 Broxton Road		2121			USA	
Maryland 21215-0036 $b\sigma S = 1\sigma/1/1916$ d 2 should be filed within 72 hours after death with the Maryland th and Mental Hyglene. Tris marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Eve Armed Forces? 1 Yes, Give X Year or Dates:	1	Was Decedent of Hispa If Yes, specity Cuban, M 1 ☐ Yes 2 X No S	inic Origin? (Spe Mexican, Puerto l <i>pecify:</i>	city Yes or No- Rican, etc.)		American Indian, White, etc. White
5-0 72 ho natur	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	edent's Usual Occupation e kind of work done durin DO NOT use retired)	n ng most of workii	ng 16	b. Kind of Busine	ess/Industry
727 Vithin	du	Elementary/Secondary (0-12) College (1-4or 5+)	life.	DO NOT use retired) Surgeon			Modi	icine
G Z filed v Hygid		17. Father's Name (<i>First, Middle, Last</i>)			. Mother's Name	(First, Middle, Ma		CITIE
e d al be	To Be	Edwin Harvey Stewart, Sr.			Rebecca		Winter	2
and N	-	19a. Informant's Name/Relationship (Type. Print)	19b. Maili	ing Address (Street and	Number or Rura	l Route Number, (City or Town, Sta	ite, Zip Code)
				04 Overbrook				
Baltimore, Dermit. Pages 1 ar Department of Heam mportant: If item 3 any Injury or other once.	П	20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State	-	ematory or other place)		<u> </u>	c. Location - City	·
Baltimo permit. Pag Department Important: I any Injury o	8	4 Donation 5 Other (Specify)	St Mary'	s Ch Cemete	erý 5/11	/2007 B	altimore	e, Maryland
Balt permit. Departr Importa any Inji	J.	21. Sign / Few ral Sonce lookee		22. Name and Address of TCHELL-WIE				
		23a. Part1. Enter the disease, or complications that caused th shock, or heart failure. List only one cause on each line.	e death. Do not en	500 York Ro nter the mode of dying, s	uch as cardiac o	r respiratory arres	Mary Land	Approximate Interval Between
Physician	7	Immediate Cause (Final disease or condition						Onset and Death
/Medical		resulting in death) a. Due to (or as a continuous)						
Examiner		Sequentially list conditions.						
l sit ed	iner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury)	consequence of):					
xecut and	Examiner	that initiated events resulting in death) Last	consequence of):					
68760, ificate be executed a physician and as the burial-transit		d						
68 rtificat ng phy as th	Medical	LE SENANCE						
Division or Vital Records, P.O. Box 6 To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf 1 □ Live birth 2 □ 4 □ Pregnant at tir 9 □ Unknown	☐ Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date o Month	
S, T	by P	Part II. Other significant conditions contributing to death but I		underlying cause given in	n Part I.	23e. Did toba	cco use contribu	ite to the cause of death?
ord equire en sig	led t	ATRIAL FIBRILLATIO	N			1 Tes	2 No 3	☐ Probably 4 国Unknown
Division or Vital Records, P.O. or Attending Physician: The law requires that the diatre death. Director: After this certificate has been signed by the lin by the funeral director, page 2 should be detached.	Completed	GILBERT'S SYNDROME				24a. Was an autopsy performe	prio	re autopsy findings available or to completion of cause of
or Vital Re hysician: The la his certificate ha I director, page 2		25. Was case referred to medical		00	N Diana of Daniel	1□ Yes 21	No 1□	Yes 2⊠No
YII s certi	o Be	examiner?	2 ER/Outpatie	Othor		n <i>(Check only one)</i> me 5 ☐ Residen		(Specify)
On Or ding Phy After this funeral c	n: To	27. Manner of Death 28a. Date of Injury	28b. Time	of 28c. Injury at		28d. Describe how		opeony)
SION (trending F leath. tor: After the funer	atio	2 Accident investigation	car, mary		2 □ No			
DIVISION Attendate de attendate	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury building, etc.	- At home, farm, s (Specify)	treet, factory, office	:	28f. Location (Stre City or Town,		or Rural Route Number,
To the Hospital or Avithin 24 hours after Completely filled in by		29a. Certifier 1 ☐ Certifying Physician: To the best of (Check only 2 ☐ Medical Examiner: On the basis of e						
To the H within 24 To the Fi complete	Medical	one) and manner state		29c. License nu				Month, Day, Year)
To To COL	2	29b. Signature and title of certifler **Muled Castila /	M.D.	RES C				100 7 Joo 7
in/		30. Name and address of person who completed cause of dea		1 10 0				/
18	1 3	KHALED CHATILA, GOOD SAME	TRITAN F	HOSPITAL S	5601 La	H RAVEN	BLUP, BA	LTIMORE, Mg 2123
	ate	31. Date filed (Month, Day, Year) 32. Registrar's	s Signature				,	
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EDWIN STEWART

		_ For	Type or Prin State of Ma		/ Depa	artment of H	lealth and	-		•	7 11.011	
		1 - State Registrar			Cei	rtificate of	Death		Reg.	No 0 0	1 14011	
Physic	cian	1. Decedent's Name (First, Middle, La	•					2. Date of Month		Day Year	3. Time of Death	
/Med		Eleanor Croxall T						May	04	•	5:36 A. M	
Exam	iner		e street and number)		4b. City, Town, o		ath		4c. County of Dea			
Funera		Gilchrist Center 5. Social Security Number 6. S	Sex 7. Age	e (In yrs. las		If Under 1 Year Months Days	WSON If Under 24 H Hours M	Irs. 8. Date of (Month)		Baltimore County irth lay, Year) 9. Birthplace (State or Fiction of State)		
Directo	r	Nov. 05,1916 Balt Usual Residence of Decedent									timore,MD.	
illed within 72 hours after death with the Maryland Hygiene. Hygiene. I Hygiene. I them 23a or 28a-f show ent, the Medical Examiner must be notified at	į	10a. State 10b. County Maryland Baltimo:	re County		Town or Lo <ville< td=""><td></td><td></td><td></td><td></td><td></td><td>10d. Inside City Limits 1 ☐ Yes 2 ☑No</td></ville<>						10d. Inside City Limits 1 ☐ Yes 2 ☑No	
the 1 28a- notifi	Funeral Directo	10e. Street and Number	Le courrey	rali	7.4.7.7.6	10f. Zip Code			10g.	Citizen of What C	ountry?	
3a or		2818 Onyx Road				21	234		Un	ited Sta	tes	
death ms 2	ler.	11. Marital Status	12. Was Decedent E	Ever in U.S.	13.	Was Decedent of H		(Specify Yes o		14. Race - Am	erican Indian,	
if e) INIAI y INIAI WATER ATA 13-0030 s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 is marked other than "natural" or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Fu		Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	No		1 ☐ Yes 2 🔀 No	Specify:	ierto nican, etc.)	Black, Whi		
72 hou hatura	Completed				16a. Dece	dent's Usual Occup kind of work done DO NOT use retired	ation during most of v	vorking	16b	. Kind of Business	Industry	
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arytarr should be ind Mental s marked o	P	19a. Informant's Name/Relationship	T 0:0	, [19h Mailii	ng Address (Street			ımber Ci	ty or Town State	Zin Code)	
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e, IV 1 and Health tem 27		Mr. Alton Bailey 1	rrueman, or		ce of Dispo	Onyx Roa sition (Name of matory or other place		rkville Date		Y Lation - City o	1234 r Town, State	
Pages nent of int: If its		1 ☐ Burial 2 【②Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci				matory or other pla neral Cha		-5-0) E	orest Hi	ll,Maryland	
DallIIIOTE, permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Funeral Service Lice		S	25	Name and Addre	ss of Facility	ives Fu	nera	1&Cremat	ion Ctr.,P.A,	
		23a. Parh. Enter the disease, or con	fur,			2325 York	Road	Timoni	um.	Maryland	21093 Approximate	
Physiciar	1	shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each lin	ne.	Do not en	ler the mode of dyn	ig, such as care	ilac oi Tespitato	ry arrest,		Interval Between Onset and Death	
/ /Medica Examine		resulting in death)	Due to (or as	a conseque	ence of):							
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	a conseque	ence of):							
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ath certi	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy							23d. Date of de	· ·	
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S, T	2	Part II. Other significant conditions	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								200	
as been signe	70	Congeiner hout	Failure, D.	asetes	mel	livs, pul	mary.	- 1	Yes	2 □ No 3 □ F	robably 4 Unknown	
he law r has be tge 2 sh	Completed by	665tavente diess	<i>t</i>					- a	Vas an autopsy performed	prior to death?	autopsy findings available completion of cause of	
VICAL iclan: T sertificat ector, pa							26 Place of I	1 Y Death (Check o	(* *	No 1 □Ye	s 2□No	
/sicla	B G	examiner?	Hospital:	ent 2∏E	R/Outpatie	nt 3 DOA Oth				6 Other (Sn	ecity) hospile	
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Attending at death.	100	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	e 290 Place of inju	ury - At hom	ne farm st	M 1 □ reet, factory, office	Yes 2 No	28f Location	on /Stree	t and Number or F	Rural Route Number,	
tal or A s after a bine by	Certification	4 ☐ Homicide determined	building, et	c. (Specity)				City or	Town, S	tate)	narar roate ramber,	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	20a Cartifier 1/2 Certifying P	hysician: To the best of miner: On the basis of and manner sta	of my know f examinatio ated.	ledge, deat on and/or ir	h occurred at the ti	me, date and plopinion, death o	ace, and due to occurred at the t	the caus ime, date	e(s) and manner a and place, and du	as stated. ue to the cause(s)	
To th withir To th	M	29b. Signature and title of certifier	4			29c. Licens	e number	i	29d.	Date signed (Mor	nth, Day, Year)	
\wedge		30. Name and address of person who	completed cause of d	eath (Item 2	23a) (Type,	Print)	7070		100	77	/	
7		Amon J - Uthan 31. Date filed (Month, Day, Year)	uts m	6701 N	J- CM	larks St	TONSON	l mo	2120	+		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Shirley Ann Tomlinson May 2007 6:30 a^M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Upper Chesapeake Medical Center Harford Bel Air 8. Date of Birth (Month, Day, Year)
MAR 23 1944 If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🕱 F 63 220-62-4371 New Jersey Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Manyland nand Mental Hygiene.

Is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 ▼No Director MD Harford Bel Air 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code ", or Items 23a or 2 kaminer must be no 2027 Fountain Green Road 21015 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Examiner 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 XNever Married 2 Married More, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 <u>Nursery Worker</u> Nursery 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Griffin William Robert Tomlinson Muriel Ada 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 33919 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 ment of Health a Glenn A. Tomlinson - brother 4140 Steamboat Bend East, Apt. 220, Ft. Myers, FL permit. Pages 1 and 2 Department of Health Important: If item 27 I any Injury or other tra once, 27 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town. State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 5/4/2007 Baltimore, MD 21. Signature of Funeral Service Licensee
Steven H. Williams 22. Name and Address of Facility
Cremation Society of Maryland,
299 Frederick Road, Baltimore, 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** lommatory 10-m/c /Medical to (or as a consequence of) Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine be executed Due to (or as a consequence of): 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the م Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Vital Records 1 | Yes 2 No 3 | Probably 4 | Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1☐ Yes certifica Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28d, Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation (Month, Day Year) Injury 1 Natural s after dea. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier Do056607 MI

State Registrar JOSEPH

31. Date filed (Month, Day, Year)

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602. S-ATWOODRd. BELATR IND

30. Name and address of per service completed cause of death (Item 23a) (Type, Print)

205

32. Registrar's Signature

ANGIZO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day FRANCIS J. TIVVIS, JR. 10:30 AM MAY 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death FRANKLIN SQUARE HOSPITAL ROSEDALE BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex Days 1 X M 2 □ F 215-54-0331 56 3/4/1951 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No MD BALTIMORE MIDDLE RIVER 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3 TAMARAC TRAIL USA 12. Was Decedent Ever in U.S. Armed Forces? 1.∯Yes 2 □ No If Yes, Give Year or Dates: VIETNAM Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛛 No Specify. Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NEVER EMPLOYED N/A 9TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) FRANCIS TIVVIS, SR. LOLA FORD 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1884 YAKONA ROAD BALTIMORE, MD 21234 LOLA TIVVIS/MOTHER 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition GARRISON FOREST 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 5/10/2007 OWINGS MILLS, MD 4 Donatjon 5 Dother (Specify) CEMETERY 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. of Funeral Service Licensee Na 8521 LOCH RAVEN BLVD. TOWSON, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hospital Acquired Pneumonia disease or condition resulting in death) Due to (or as a consequence of) cellulitis Sequentially list conditions if any leading to immediate cause. Enter Underlying Cause (Disease or injury that introduced in the control of t Due to for as a ponsectioning of Peripheral vascular disease that initiated events resulting in death) Last Due to (or as a consequence of): DM 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) □Yes 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Renal Failure, CHF, Anemia, HTN 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 1□ Yes 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 XInpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify)

Physician /Medical Examiner attending physician and for use as the burial-transit

Physician

/Medical

Director

Funeral

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Completed

Be

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Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" --- any injury or other traumatic events.

Examiner Physician/Medical signed by the a 9 Completed Be ဥ Certification: Medical

or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760. has e 2 s certificate ha irector, page ? Director: after within 24 hours a

To the Funeral I

completely filled



25. Was case referred to medical 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c 28d. Describe how injury occurred Injury at Work? Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check o 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29b. Signature title of g 29c. License number 29d. Date signed (Month, Day, Year) H0052024

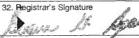
who completed cause of death (Item 23a) (Type, Print)

2007

MAY 0 8

Welker, MD 9000 Franklin Square Drive Baltimore, MD 21237

31. Date filed (Month, Day, Year) State Registra



Registrar

State

29b. Signature and title of certifier

Rm 206

31. Date filed (Month, Day, 32. Registrar's Signature Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mar-OKIOD



29c. License number

03/865

29d. Date signed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month ()24 **Physician** 2.ŎĈĨŹ 5:50 P M Margrelita Michelle Thomas /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Franklin Square Millenium Nursing Home If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 ☐ M 2 🖫 F 39 218-74-6831 Director 08/07/1967 MD Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits show r 28a-f show notified at 1 Yes 2 □ No Director Baltimore MD 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code ms 23a or 7 21201 USA 802 West Lexington Street Funeral permit. Pages 1 and 2 should be filed within 72 hours after dea. Department of Health and Mental Hygiene. Important: If them 27 is marked other them." 7 is marked other than "natural", or items traumatic event, the Medical Examiner m 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married African American 1 □ Yes 2 No ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) housewife domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James A. Thomas Virginia Barnes ျ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2526 Loyola Southway; Baltimore, Maryland 21215 Roland J. Elmore / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 05/11/2007 Metro Crematory Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wylie Funeral Home, P.A. 21. Signature of Funeral Service Licenses 638 N. Gilmor Street; Baltimore, MD 21217 حسح 23a. Part1. Enter the disease, or complicate as that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Acquired terminal Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any loading to manufact cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examiner and burial-trar Due to (or as a consequence of): the IF FEMALE use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1☐ Yes 2 ☑ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State)

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, after death. filled in by 24 hours a Funeral I within 2

6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 03/865 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Medical

206

821

Gutan N.

32. Registrar's Signature 31. Date filed (Month, Day, Year)

Street

4b. City, Town, or Location of Death

Rockville

Months Days

Udovich

Widdowson

77

7. Age (In yrs. last birthday)

If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

2. Date of Death

Day

3

February 13, 1930

2007

4c. County of Death

Montgomery

Month

May

3. Time of Death

3:30

Birthplace (State or Foreign Country)

10d. Inside City Limits 1 X Yes 2 □ No

Maryland.

	how		10a. State	10b. County		10c. City, Town	n or Location						10d. Inside City Limits		
	the Marylar 28a-f ehow	ctor	Maryland	Montgo	omery	R	ockvil	le					1 No Yes 2 No		
	or 28	lre	10e. Street and Nur	mber	Zip Code			10g. (Citizen of What Co	ountry?					
	within 72 hours after death with the Marylar ane. then "naturet", or tems 23a or 28a-f ehow he Medical Examiner must be notified at	Funeral Director	303 Adclare Road 20850								Un	United States			
	or thems	ner	11. Marital Status		12. Was Decedent E Armed Forces?	ever in U.S.	13. Was De	cedent of H	ispanic Orig	in? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Ame Black, Whit			
9	afte or tt	F		ied 2 ☐ Married	1 ☐ Yes 2 🖾 No				Specify:						
8	Junet',	d b	3 Widowed	4 🗓 Divorced		1 ☐ Yes 2X No Specify:						Specify: White			
21215-0036	72 hours "naturet",	ete	(Spec	15. Decedent's Ed hify only highest grad	ucation de <i>completed)</i>	16a.	ia. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Montgomers						•		
12	within then then	Completed by	Elementary/Seco	indary (0-12)	College (1-4or 5	Teach		0			higomery blic Sch				
	filed Hygie offher filed	ပိ	17 Father's Name	(First, Middle, Last)	5+		Teach	=1	18 Mother	's Name (First Min					
Maryland	o d a b	Be c	m l									on Sumame)			
2	should ind Men i marke umatic	ဥ		ame/Relationship (T	vne Print)	19h	Mailing Addr	oss (Straat		or Rural Route Nu		or Town State	Zin Cada)		
Ma	d 2 sho th and t7 is ma treuma				/ Daughter						-		yland 21213		
	1 and Health Iem 27		20a. Method of Disg		/ Budgilesi	20b. Place of	Disposition (Name of	Ţ	Date	_	Location - City or			
<u></u>	Peges nent of int: if it			Cremation 3 🗀			atory or other place) May 9,								
Baltimore,		l i		5 Other (Specify, meraf Service Ligens		Deechw	rood Ce			2007			, Maryland		
Ba	permit. Departr Importueny inju		Mass	lette Bar	_	M01305	Robert	A. Pum	phrey I	uneral Home	/Rock	wille, Inc	2.		
	_		23a. Part 1. Forer th	0.00	lications that caused							e, Marylar	nd 20850-2805 Approximate		
			shock, or heart failure. List only one cause on each line.												
	Physician /Medical		disease or condition resulting in death)	n	a Sepsi								Days		
	Examiner			- 1	•	consequence	,								
		6	Sequentially list con	nditions.		ry Traci		etion					Days		
W	ted nsit	Examiner	Sequentially list con in any, leading to in cause. Enter Unde Cause (Disease or that initiated events	rlying	•	nson's l	•	a					Years		
Ĭ,	xecu and	хаг	that initiated events resulting in death) I	ast	Due to (or as a consequence of):										
9	sicier buri	al													
68760,	ficate p physics the	edlo			a										
Вох	ian: The lew requires that the death certificate be executed rificate hes been signed by the ettending physicien and ctor, page 2 should be detached for use as the buriat-transit	Physician/Medical	IF FEMALE: 23b. Was decedent	toregnant	23c. If yes, outcome of	of pregnancy						23d. Date of del	livery		
	Jeath ette	cia	in the past 12	months?	1 ☐ Live birth : 4 ☐ Pregnant at		3 □Ectopio 5 □ Other	pregnancy (specify)				Month	Day Year		
P.O.	that the de ned by the e detached t	hys	9 Unknown	3140	9□ Unknown				·						
	res that igned to be deta	by P	Part II. Other signif	icant conditions co	ntributing to death bu	t not resulting in	the underlyin	g cause give	n in Part I.	23e. D	id tobacco	use contribute to	the cause of death?		
ğ	auire n sig uld bu	P								1	Yes	2⊠No 3□Pr	obably 4 Unknown		
ital Records,	w requires been si	Completed								24a. W	as an	24b. Were au	utopsy lindings available		
Re	he le e he: sge 2	E								au	itopsy erformed?	death?	utopsy lindings available completion of cause of		
tal	cian: The lew ertificate hes l ector, page 2 s	e C	25. Was case refer	red to medical					OC Diago		s 2 🔀 N	lo 1 Yes	2 No		
>		To B	examiner? 1 ☐ Yes 2 🔯	1	Hospital: 1 □ Inpatier	nt 2 ER/Out	tnatient 3	DOA Othe		of Death (Check on sing Home 5 🗆 R		€ □Other /Sec	out al		
0	a Phy eral c		27. Manner of Death		28a. Date of Injun (Month, Day		ime of	28c. Injury Work				ury occurred	City)		
Division	t or Attending Physic after death. Director: After this ce I in by the funeral direc	딅	1 X Natural 2 ☐ Accident	5 Pending investigation	(Month, Day	rear) ir	njury M		(? /es 2 □ N	0					
<u>Vis</u>	Atte	₩	3 Suicide	6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office					28l. Locatio	(Street a	and Number or Ru	ural Route Number,		
Ō	s afte	Certification;	4 ☐ Homicide building, efc. (Specify) City or Town,							rown, Sta	ite)				
	To the Hospitet or Attending P within 24 hours after death. To the Funerei Director: After the completely filled in by the funera		29a. Certifier	1 Certifying Phy	sicien: To the best o	f my knowledge	, death occurr	ed at the tim	e, date and	place, and due to t	he cause(s) and manner as	stated.		
	he H in 24 he Fu pletel	Medical	(Check only one)	Z Medical Exemi	ner: On the basis of and manner stat	examination and	vor investigat	ion, in my op	oinion, death	occurred at the tin	e, date a	nd place, and due	to the cause(s)		
	To t To t	Σ	29b. Signature and	title of certifier	. 11	1		29c. License	number		29d. D	ate signed (Monta	h, Day, Year)		

23d. Date of delivery Month Year use contribute to the cause of death? X No 3 Probably 4 Unknown 24b. Were autopsy lindings available prior to completion of cause of death?

1 □ Yes 2 □ No 6 ☐Other (Specify) ry occurred nd Number or Rural Route Number, 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 1201 Seven Locks Road, #202, Rockville, Maryland 20854

State Registrar

30. Name and address of person who completed cause

Frauke Westphal, M.D.

1. Decedent's Name (First, Middle, Last)

5. Social Security Number

217-30-9348

Usual Residence of Decedent

Catherine

1 □ M 2 🖾 F

4a. Facility Name (If not institution, give street and number)

Rockville Nursing Home

Physician

/Medical

Examiner

Funeral

Director

of death (Item 23a) (Type, Print)

D0019785

State Registrar

DHMH 17 Rev 1/2001

lavanar

tmba

31. Date filed (Month, Day, Year)

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			1 _ For	State of Man		artment of H	ealth and M	-	_	7 -7	11010		
			= State Registrar		Cei	rtificate of L	Death		g. No	3.1	14010		
	Physici	an	Decedent's Name (First, Middle, Last)	,				Date of Death Month	Day	Year	3. Time of Death		
	/Medic		togar b	veigan	d			5		7	Z: OUPM		
	Examin	er	4a. Facility Name (If not institution, give s				Location of Death		4c. County	of Death			
			Charlestown Care () Caton	sville	O Data of Birth	Bal	timo			
	Funeral Director		215-09-5802 1X	M 2□F 7. Age (/	n yrs. last birthday) 4 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 05/10/19	Year) 912		lace (State or Foreign htry) yland		
	and w		Usual Residence of Decedent 10a. State 10b. County		1	0d. Inside City Limits							
	death with the Maryland rma 23a or 28a-f ehow r must be nutting at	to	MD Balti	more		Catonsvil	.le				1 ☐ Yes 2X No		
	1 the	Funeral Director	10e. Street and Number			10f. Zip Code		10	10g. Citizen of What Country?				
	h with	a D	707 Maiden Choice	Lane Apt.	3411	212	28		Unit	ed S	tates		
	deal	ner	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S. 13.	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Spe	ecify Yes or No-		- Americ	an Indian,		
36	within 72 hours after ene. then "naturel", or Ite he Wedical Exemine	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:	-	1 ☐ Yes 2 No		riodii, oto.,	Specify: White				
ŏ	2 hou	Completed	15. Decedent's Edu	cation	16a. Deced	dent's Usual Occupa	ation	1	6b. Kind of Bu	siness/In	dustry		
21	thin 7	npie	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	lite. I	kind of work done of DO NOT use retired)	ng					
2	filed wi Hygien other th	် ပ		2	Prin	ter					ndustry		
p	tal H d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name			θ)			
₹	should nd Men marke umatic	၉	Anthony Weigand					na Spahr					
Maryland 21215-0036	d 2 th a train	j	19a. Informant's Name/Relationship (Ty). H. Charles Weigand			ng Address (Street a Redgate C			-				
ē,	ss 1 a of Hei Item		20a. Method of Disposition		20b. Place of Dispo	sition (Name of matory or other place	p) D	ate 2	0c. Location -	City or To	own, State		
Ĕ	Page nent ant: If ury or		1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Most Hol	y Redeeme	r 05/10	/2007	Baltim	ore,	Maryland		
Baltimore,	20a. Method of Disposition 1 28 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Service Licensee 4 107 Wilkens Avenue, Baltimore								neral M	Home,	, Inc.		
			23a. Part1. Enter the disease, ol compli	eations that caused the				· · · · · · · · · · · · · · · · · · ·		II y I c	Approximate		
1	Physician		shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.	^						Interval Between Onset and Death		
	/Medical		disease or condition resulting in death)	Due to (or as a c	onsequence of):	د							
	Examiner												
	pg tis	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter or Jeanying Cause (Disease or injury										
	be executed icien and burial-transit	хаш	that initiated events resulting in death) Last	Due to (or as a c	onsequence of):					-			
760,	be exicient	caiE											
687	icate phys s the			l									
×	certif nding use a	Ž.	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of p					23d. Date	e of delive	erv		
P.O. Box	The law requires that the death certificate be executed thes been signed by the attending physicien and page 2 should be detached for use as the buriat-transit	Completed by Physician/Med	in the past 12 months? 1 Yes 2 No 9 Unknown		Month Day Year								
٦.	that t ed by deta	'Ph	Part II. Other significant conditions con	tributing to death but n	ot resulting in the u	nderlying cause give	en in Part I.	23e. Did tob	acco use contr	ibute to the	ne cause of death?		
Sp.	uires sign ld be	d b	Colonary Ar	tery Di	sease			1 ☐ Ye	s 2 □ No	2 No 3 Probably 4 donknown			
Ö	w require been sig should b	ete	Atrial fibri	11 500				24a. Was an	24b V	Vere auto	psy findings available		
Re	he lav e hes	E C	_ My ac 11011	VI BEVIOU				autopsy	ed?	rior to co eath?	mpletion of cause of		
tal	ysician: The l is certificete he director, page	a)	25. Was case referred to medical				26. Place of Death			□Yes	2 No		
>	/sicie	To B	evaminer?	lospital:	2 ER/Outpatien	nt 3 DOA Othe	-	ne 5 ☐ Reside		ar (Specif	w)		
0	a Phy er thi		27. Manner of Death	28a. Date of Injury (Month, Day Y	28b. Time of			28d. Describe ho			7/		
<u>o</u>	nding ath. r: Aft	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day 1	ear) Injury		res 2 □No						
Division of Vital Records,	or Atte	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury building, etc. (- At home, farm, str Specify)	eet, factory, office	2	28f. Location (Str City or Town	eet and Numbe State)	er or Rura	l Route Number,		
_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Diractor: After this certific completely filled in by the funeral director,	Medical Ce	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	sician: To the best of ner: On the basis of example and manner stated	amination and/or in	n occurred at the tim vestigation, in my op	ne, date and place, a pinion, death occurre	and due to the ca ed at the time, da	use(s) and ma te and place, a	nner as s	tated. o the cause(s)		
	To the within 2 To the comple	Me	29b. Signature and title of certifier			29c. License	number	29	d. Date signed	(Month,	Dey, Year)		
	⊢ < ⊢ ŏ		× Oa	B. O.		D44	227		5/7				
	111		30. Name and address of person who co	mpleted cause of deat	h (Item 23a) (Type.	Print)	OTH		0/7	7			
	1511		Deneen Bowlin.	mp 711	Maiden	Chrice	Lave. C	atonsvi	ille.	mn	21228		
2	Sta		31. Date filed (Month, Day, Year)	32 Hegistrar s	Signature								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death MAY **Physician** 5:25PM SECOND **Emily Whye** 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A BALTIMORE 4000 SAMPRITAN HOSP ITAL if Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days 1 M 2 V Maryland Dec 15, 1925 Director 214-24-9169 81 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10b. County r 28a-f show notified at 1 □ ¥es 2 □ No Director N/A Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a or iner must be n U.S.A 21239 6401 Loch Raven Blvd. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status "natural", or Item edical Examiner Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black Specify: þ 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Own Home Elementary/Secondary (0-12) College (1-4or 5+) Homemaker marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Emma F. Hammond Calvin G. Jackson မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 46 Barnacle Court Essex, Maryland 21221 Deborah Whye Daughter Important: If Item 27 any Injury or other to once. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Borial 2 □ Cremation 3 □ Removal from State 05/09/01 Owings Mills, Md. Garrison Forest Veterans Cemetery 4 Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Battimore, Md 21217 23a. Part1. Enter the disease, or complications that cause? the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ACUTE MYDCARDIAL INFARLTION disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PULMONARY EDEMA Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence oi). Examiner CORUNARY DISEASE ARTERY attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 ☐ Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ALUTE RENAL 1 Yes 2 No 3 Probably 4 Onknown FALLURE FAILURE 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No RESPIRATURY 24a. Was an autopsy 2/2 No this certificate 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

To the Hospital or Attending PhysIclan: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, To the Funeral Director: After the completely filled in by the funeral within 24 hours a To the Funeral I

> State Registrar

(Check only one)

KOSHAN

29b. Signature and title of dertifier

31. Date filed (Month, Day, Year)

MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHAWALE

5601 LOCH

32. Rastrar's Signature

DHMH 17 Rev 1/2001

RAVEN

29c. License number

RESOOD

BUD

29d. Date signed (Month, Day, Year)

MAY. 2nd, 2007

MD 21239

BAUIMORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 3:00 p M 2007 MAY John Francis Weber 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) BA († 1700). If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 19 itimore HOSPITAL Agnes 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 ★ M 2 🗆 F 69 212-34-4619 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County MDBaltimore Arbutus 1 ☐Yes 2 ☐ No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21229 U.S.A. 913 Leeds Avenue 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ☑ Yes 2 ☐ No If Yes, Give 1960-64 Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 🙀 No Specify: Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Tile & Marble <u>Specialist</u> Construction 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elsie Leonora Lester William John Weber 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 913 Leeds Avenue Arbutus MD 21229 Bernadette C. Weber/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Conation 5 ☐ Other (Specify) 5-08-2007 Loudon Park Cemetery Baltimore, Maryland 21. S malure of Funeral Service Licentee Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Atherosclerotic Heart Disease Due to (or as a consequence of): pertension if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hyper cholesterolemiA Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Trinknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 🎞 oo performe 2 NO 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Yes 2 No 1 Inpatient 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Physician /Medical Examiner The law requires that the death certificate be executed for use as the burial-transit Division or Vital Records, P.O. Box 68760, physician s been signe should be d cate has page 2 s Hospital or Attending Physician: funeral within 24 hours after death

To the Funeral Director:
completely filled in by the

Physician

/Medical

Examiner

Director

Completed by Funeral

Be

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, the Medical Examiner must be notified at once.

3altimore, Maryland 21215-0036

Physician/Medical Examiner Be Completed by Medical Certification: To 3 Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

29b. Signature and title of certifier

and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

hysiciAn 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D0024228

Agnes Hospita

200+

JR,MD Frenchick

32. Registrar's Signature 31. Date filed (Month, Day,

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** WHALEN MA SINTHER 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ANDAIS TOUR HESPITALLENTA BALTIMONE NonTHIOSO If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours 1 □ M 2 🔀 F 49 58 MD Director 214-70-9550 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene. 'Is marked other than "natural", or items 23a or 28a-ք «հռա 10d. Inside City Limits 10c. City. Town or Location 10a. State ıral", or items 23a or 28a-f show I Examiner must be notified at 1 ☐ Yes 2 No Directo Baltimore Catonsville MD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number U.S.A. 21228 3 Winesap Ct. Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1X Never Married 2 Married 1 ☐ Yes 2 X No Black Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Beazim Laborer 12th grade 2yrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Oleather Sinclair ဥ Woodrow Whalen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 s ment of Health an ant: If item 27 is 1 Department of Health Important: If item 27 any Injury or other troonce. Winesap Ct., Catonsville, Md Woodrow Whalen-Brother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland National 5/7/07 Laurel, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West 4nom DSon 21215 4300 Wabash Ave, Baltimore, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician SEPSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner DSTUDEMONTS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner METHICIKEN requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the salould be detached 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe Yes 2 has page 1 ☐ Yes 2 1 No After this certificate CANDIOVASCULA or Attending Physician: 25. Was case referred to medical examiner? director, 26. Place of Death Check onl one Medical Certification: To Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 Datient 2 ☐ ER/Outpatient 3 ☐ DOA Date of Injury (Month, Day Year) funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fi death. 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

3

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

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Records,

or Vital

Division

State Registrar 29b. Signature and title of certifie

ORIANDO 31. Date filed (Month, Day,

Year!

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

		For State		State of	f Marylan		rtment of H tificate of L		nd Men			200-	7 11.000		
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Funeral		5. Social Security N		Sex 1.\$37M 2.□F	7. Age (In yrs.	Yrs.	Months Days	Hours	Min.	(Month, Day	y, Year)		thplace (State or Foreign ountry)		
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and *	ŀ	10a. State	10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside City Limits		
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he N	Director	MD	BALTIMO)KE		CA	CATONSVILLE 10f. Zip Code 10g. Citizen of What Country?								
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H.,													
90 E # 9		701 LAURENS ST., BALTO., MD 21217													
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F > F O		1	0				1 -	-5-11							
		W.u	m D			wil	1 44	J 42	7		2/7	10)			
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9	Dhusisi	75,	Decedent's Name (First, Michael Control of the	ddle, Last)					2. Date Mon	of Death		Year	3. Time of Death	10
	Physicia /Medic		LOUISE	D.	WHIT	E			MAY	Y 6 2007 6:0			6:00 A.	1
	Examin	er	4a. Facility Name (If not institute WINTER GROWTH			4b. City, Town, o	r Location of LUMBIA		4c. County of Death HOWARD					
100	Funeral Director		5. Social Security Number 216–20–5532	6. Sex 1 □ M 2 X F	7. Age (In 83	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 2	Min. (Mor	of Birth th, Day, Ye	ar)	9. Birthpl Coun	ace (State or Foreig try) VA	n
	D		Usual Residence of Decedent						JUNE	/, 1	723			_
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	the M 28a-f notifie	Director	MD E	IOWARD		ELLICO	TT CITY 10f. Zip Code			10g.	Citizen of W	hat Coun		
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21215-0036	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show deal Examiner must be notified at	ted	15. Deced	lent's Education			dent's Usual Occup		16b	. Kind of Bus	iness/Inc	lustry		
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e, Z	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		CIFTON F. WHI'	TE, SR./SO		914 0b. Place of Dispo	sition (Name of	TAYMON	DRIVE,		Location - C			
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Вох	leath certifii attending p I for use as	ian/l	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	outcome pf pre e birth 2 gnant at time	Fetal death 3	□Ectopic pregnanc □ Other (specify) _	y			23d. Date of delivery Month Day Year			
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alF	(0 [05 W	f4						performed Yes 2 12		eath?	2□ No	
or Vital Records,	Physician: this certific	o Be	25. Was case referred to med examiner? 1 ☐ Yes 2 ☒ No	Hospital:	☐ Inpatient	2 ER/Outpatier	nt 3 DOA Oth		of Death <i>(Check</i> sing Home 5		e 6 ∏Othe	r (Specif	<i>(</i>)	
n Of		-	27. Manner of Death 1 Natural 5 □ Pen	/1 /	te of Injury onth, Day Ye	28b. Time o					njury occurre		<u>/</u>	
Division	ttendir death. ctor: A	catic	2 ☐ Accident inve	estigation	on of injury	At home form et		Yes 2□N		otion (Ctoon	t and Mismba		I Pouto Mumber	
DİVİ	after of Direct of in by	Certification:	4 ☐ Homicide dete	ermined 206. Fla	ilding, etc. (S	pecify)	reet, factory, office		City	or Town, S	tate)	i oi nuia	l Route Number,	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune	ledical C		fying Physician: To to cal Examiner: On the										
	the P	Medi	29b. Signature and title of cen		AAD		29c Licens	se number		29d_	Date signed	(Month.	Dav. Year)	_
	F 3 F 8	1		'ar			03	3107	6	15	171	07	•	
	1		30-Name and address of pers	on who completed ca	use of death	(Item 23a) (Type,	Print)	10-11	04.0	0-	01	7 1	0 2123	7
	Ŋ		21 Date filed (Marth Day V	A 550N	Registrar's	, 9(0(· porce	TUEL	(121/2)	160,	17/11	UN	0 40)	
	Sta Registi		31. Date filed (Month, Day, Ye		Hegistrars		retur							

DHMH 17 Rev 1/2001

		For L State	Plea				l / Dep	ndelible Ink. partment of H e <i>rtificate of I</i>	ealth	and M	lental Hy	giene	gible.				
Physicia	_	= State Registrar 1. Decedent's Nam Doris		le, Last)		- 0	erinicale of i	ı									
/Medic Examin		4a. Facility Name (If not institutio	n, give street and no sted Livi			4b. City, Town, or Location of Death Reisterstown					May 6 2007 6:30 4c. County of Death Baltimore					
Funeral Director					e (In yrs. last birthday) If Under 1 Year If Under Months Days Hours			der 24 Hrs. 8. Date of Birth			9. Birthplace (State or Foreign Country) Maryland						
Maryland f show ed at	ō	Usual Residence of 10a. State	10b. County	imore	,	Town or	Location	_					10d. Inside City Limits 1 ☐ Yes 2 🛣 No				
h with the I	Funeral Director	10e. Street and Number 639 Main Street				Ke	istei	10f. Zip Code 2113	6		10g. Citizen of What Country?						
urs a al', o xarr	þ	11. Marital Status 1 □ Never Mari 3 ▼Widowed		If Yes, G	orces? 2[X]N ive	Ever in U.S √o	10	3. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🗶 No		14. Race - American Indian, Black, White, etc. Specify: White							
0 0 0	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5-				+)	(Gi life	cedent's Usual Occup we kind of work done on the DO NOT use retired of Operator	during mo ()	ost of work	ing	16b. Kind of Business/Industry Telephone					
oe fil d oth	To Be Co	17. Father's Name (First, Middle, Last) Arthur Rothauge							18. Moti	ula	Waterw	First, Middle, Maiden Surname) Waterworth Route Number, City or Town, State, Zip Code)					
1 and 2 sho Health and Iem 27 is m		19a. Informant's N Louis T. 20a. Method of Dis	. Bosse	ship (Type. Print)	son	20b. Pl	461 ace of Dis	5 Sherwood	Mil	ls Ro		ings M		MD 21117			
permit. Pages Department of Important: If i any Injury or once.		4 ☐ Donation	5 ☐ Other (3 □Removal from Specify)		Met		rematory or other place rematory, 22 Name and Addres Cremation	Inc				more,	MD			
Physician / Medical Examiner provided the prival-transit	dical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):															
the death certific y the attending p tohed for use as	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐ 9 ☐ Unknown									23d. Date of delivery Month Day Year						
equires that en signed b	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Monknown															
n: The law r ificate has be or, page 2 sh	e Completed	24a. Was an autopsy findings available autopsy performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one)										completion of cause of					
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after detects. After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the burn	Certification: To Be	examiner? 1 Yes 2 27. Manner of Dea 1 XNatural 2	No 5 Pendi invest	Hospital: 1 E 28a. Dat (Mo	ry y Year)	28b. Time Injur	26. Place of Death (Check only one) /Outpatient 3 □ DOA Other: 4 □ Nursing Home 5 □ Residence ib. Time of Injury M 1 □ Yes 2 □ No , farm, street, factory, office 28f. Location (Street ar City or Town, State)					rry occurred Living and Number or Rural Route Number,					
the Hospitz hin 24 hours the Funeral npletely filled	Medical C	29a. Certifier (Check only one)	2 Medica	Examiner: On the and ma		f examinat		eath occurred at the til r investigation, in my c	pinion, d	leath occur		, date and pl	ace, and due				
7 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	4		en	n who completed ca		,	23a) (Typ	0:	72 8	PI		-/	2/2	7			
Sta		31. Date filed (Mo	£ L.	Mois	1	ar's Signa	ure	rints!	C+	at .	Us.	R.	e. 1	21/3			
Registr 0HMH 17 Rev 1/2		1	9 O YAR	2007	A COL	1 13	fit		<u> </u>								

2007 14825

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Patrick Washington Certificate of Death 1- For State Reg. No 3. Time of Death Registrar 2. Date of Death Decedent's Name (First, Middle,Last) May 4, 2007 Physician/ 0108 hrs Examiner Μê Antonia 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** Randallstown Northwest Hospital 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Foreign Funeral Days Months Country) Director 1 X M 2 Usual Residence of Deceden 10d. Inside City Limits IOc. City, Town or Location 10a. State 10b. County Yes 2 No permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No Funeral 12. Was Decedent Ever in U.S. 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces' 2 Yes Specify: Yes 2 X No specify: f Yes, Give Year 4 Divorced Widowed ş 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 18.Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Be (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address Informant's Name/Relationship (Type, Print) B Date 20c. Location - City or 20b. Place of Disposition (Name of cemetery, . Method of Disposition Baltimore, crematory or other place) 2 Cremation 3 Removal from State Donation 5 Other Specify · Green funion Seilie aughu C 22. Name and Address of Facil Signature of Funeral Service Lite complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 23a. Part I. Enter the disease, or Between Onset and ysician failure. List only one cause on each line Death **Jedical** a. Atherosclerotic Cardiovascular Disease complicated by Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of) b. Head Injuries Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit sician/Medical AMENDED UNPENDED red by the attending physician detached for use as the burial the Hospital or Attending Physician: The law requires that the death certificate be-23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Day Year 3 Ectopic pregnancy 23b. Was decedent pregnant in the Fetal death Live birth past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Phy 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions Ö Yes 2 ✔ No 3 Probably 4 Unknown þ σ. Morbid Obesity 24b. Were autopsy findings available Completed Division of Vital Records, has been si 24a, Was an prior to completion of cause of autopsy death? performed? 1 🗸 Yes No ✓ Yes 2 No. page certificate 26.Place of Death (Check only one) 25. Was case referred to medical director, Be Other₄ Residence 6 Other: Hospital: 1 / Inpatient Nursing Home 5 DOA ER/Outpatient 3 this 1 V Yes ဥ 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) FOUND: 27. Manner of Death After Subject fell Certification: FOUND Yes 2 ✔ No Natural Pending 0040 hrs hours after death. To the Funeral Director: May 4, 2007 28f. Location (Street and Number or Rural Route Number, City 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be or Town, State)
Summit Park Rehab. Ctr., Catonsville, MD 3 Suicide determined (Specify) Nursing Home 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 24 Medical within 2 and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b Signature and title of certifier May 4, 2007 O.C.M.E 30. Name and address of person who complet id cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner

32. Registrar's Signature

ORIGINAL

Susan Hogan MD.

31. Date filed (Month, Day, Year)

State

			- FUI		rtment of Health and M	, .	000-11000
_			1 - State Registrar	Cer	tificate of Death	Reg.	
	Physici		1. Decedent's Name (First, Middle, Last) DOROTH7 B WEL	CH		2. Date of Death Month MA7	Day Year 2007 6.00 AM
N.	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
1			SUMMIT PARK		CATONSVILLE		BALTIMORE
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. las		If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birthplace (State or Foreign Country)
	Director		213-28-9459 1 M 200F 7	G Yrs.		10-01-	1930 Ga.
	yland			Town or Loc	cation		10d. Inside City Limits
	e Mar	ctor	MD Battimone G	nw yn	nn OAK		1 □ Yes 2 ☑ No
	or 28	Dire	Toe. Street and Number	0	10t. Zip Code	10g.	Citizen of What Country?
	s 23s	Funeral Director			21244		USA
	fter d	Fun	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 □ 1 □ Ye	ls. V	Vas Decedent of Hispanic Origin? (Spi Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	14. Race - American Indian, Black, White, etc.
98	ours a	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1	Yes 2 Specify:		Specify: BIK
21215-0036	filed within 72 hours after death with the Maryland Hyglene. ther then "naturel", or Items 23a or 28e-f show ant, the Madical Examiner must be multiled at	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give I	ent's Usual Occupation kind of work done during most of work	king 16b	. Kind of Business/Industry
121	within ane. then	mpi	Elementary/Secondary (0·12) College (1-4or 5+)	5 1	OO NOT use retired)		Domestic
	filed Hygie other ent,	e Co	17. Father's Name (First, Middle, Last)			ne (First, Middle, Maid	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if Item 27 is marked other then "naturel; or Items 23s or 28e-f show any injury or other treumatic event, the Madical Examiner must be notified at once.	To Be	Willie Bell		matti	e Ma	e Ector
dary	2 sho and h is ma		19a. Informant's Name/Relationship (Type, Print) Davette MC Donald (Daustus)	19b. Mailin	g Address (Street and Number or Ru		
	1 and Health em 27 ther tr		20a. Method of Disposition 20b. Plan	143	30 Barrett 12		Location - City or Town, State
Baltimore,	Pages nent of P ant: If Ite		1 □ Burial 2 □ Cremation 3 □ Removal from State cen	natani ciam	ratoni or other place)		
alti.	permit. P Departme Importen any injur.		' 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee	rhut 22.	Name and Address of Facility	C Grant	Baltimore, MD. e Funcial Suc. 11stown MD. 21133
ñ	Depa Impo any is		Naugne In	8-	128 Liberty ed	fandal	15+0NN MD 21123
r	97		23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each fine.	Do not ente	or the mode of dying, such as cardiac	or respiratory arrest,	Approximate interval Between
Sept.	Physician		Immediate Cause (Final disease or condition HEPATO CEL	LLUL	AR CARCINOI	MA	Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a conseque				
		er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a conseque	nce of):			
	d d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c. HTPFRT	ENS-1 O	\sim		
oʻ	ate be executed hysician and the burial-transit	Exa	resulting in death) Last Due to (or as a conseque	nce of):			
8760,		dicai	d				
9 X	thet the death certific ed by the attending p detached for use as i	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnance	ev			224 2 4 4
Вох	death atten	cian	in the past 12 months?	léath 3□I	Ectopic pregnancy Other (specify)	_	23d. Date of delivery Month Day Year
P.O.	by the	hysi	1 Yes 2 No 9 Unknown 9 Unknown				
	The law requires thet the ate has been signed by the page 2 should be detached.	by P	Part II. Other significant conditions contributing to death but not resulti	ing in the un	derlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?
ord	w requir been si should					1 🗆 Yes	2 No 3 Probably 4 Unknown
Sec.	e law has b	Completed				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
a F	ilcien: The l					performed 1 ☐ Yes 2 ☑	
5	yslcien: nis certifica director.	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 E	R/Outpatient	Other	th (Check only one)	6 □Other (Specify)
) Of	Attending Physicien: r death. sctor: After this certification in the funeral director.		27. Manner of Death 28a. Date of Injury 2	8b. Time of	28c. Injury at Work?	28d. Describe how in	
sior	endin sath. or: Af	atio	2 Accident investigation	injury	M 1 Yes 2 No		
Division of Vital Records,	or Att	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At hom building, etc. (Specify)	e, farm, stre	et, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
_	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	ai Ce	29a. Certifier 12 Certifying Physician: To the best of my knowle	edge, death	occurred at the time, date and place	and due to the cause	a(s) and manner as stated
	n 24 h	edicai	(Check only 2 Medical Examinar: On the basis of examination one)	n and/or inve	estigation, in my opinion, death occur	red at the time, date	and place, and due to the cause(s)
	To th To th comp	M	29b. Signature and title of certifier	~0	29c. License number		Date signed (Month, Day, Year)
	1		+ HIEMOIN	15	84621000		MY 3 rd 200)
	6		30. Name and address of person who completed cause of death (frem 2			DAAT MA ON E	40 200
	Sta	te			PLACE SUITE 3H	is TO LINE BICC	19 61618
4	Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signatur MAY 0 8 2007	100	while the same of		
			111111111111111111111111111111111111111				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) **Physician** /Medical 4a Examiner 5. 5 **Funeral** Director Usi 10 r 28a-f shov notified at M: items 23a or 2

MARI	A	ZACHA	RKIW							Ma	y 2	, 2007		6:12	P^{M}	
4a. Facility Name (II	not institution	n, <i>give str</i> eet an	d n <i>umb</i> er)			4b. City,	Town, or	Location	of Death			4c. Count	y of Deat	th		
Greater	Balti	more Me	dical	Center	c	Towson						Baltimore				
5. Social Security N 220-94-5		6. Sex 1 ☐ M 2 [X		e (In yrs. last b		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of (Mont) Mar.	h, Day,	Year) , 1927	Co	thplace (State ountry) Land	or Foreign	
Usual Residence of	Decedent															
10a. State	10b. County			10c. City, Tov	vn or Loca	ation								10d. Inside C	ty Limits	
Maryland	N	/A		Ba1	timo	re								1 X Yes	2 🗆 No	
10e. Street and Nur	mber					10f. Zip	Code				10	g. Citizen of	What Co	ountry?		
6125 No	orth Ch	narles S	Street	:		21212 U.S.A					,					
11. Marital Status		12. Was	Decedent E	ver in U.S.	13. W	as Dece	dent of H	spanic Or	rigin? (Sp	ecify Yes	or No-		ce - Ame	rican Indian,		
1 Never Marri	ed 2 Marr	ied 1 🗆	res 2 X N	lo		_				riicari, etc	··)	Die	ack, vviii	e, etc.		
3 Widowed	4 Divorced	I If Ye	s, Give or Dates:		1	Yes	2 X No	Specify.	:			Spec	ify: Wh	nite		
(Spec	15. Deceden	t's Education st grade comple	ted)	168	a. Decede		rk done d	<i>luri</i> na mos	st of worl	k <i>i</i> ng		16b. Kind of I	Business/	Industry (
Elementary/Secondary (0-12) College (1-4or 5+) 12 years						emolo		,				Je	ewe1e	ery		
17. Father's Name		Last)							er's Nam	e (First, M	iddle, N	1aiden Surna	me)			

Certificate of Death

Physician /Medical **Examiner**

physician a s the burial-1

attending pl

Be Completed by

Certification: To

Medical

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Department of Health Important: If Item 27 any Injury or other tr

Health and Mental Hygiene. em 27 is marked other than "natural", or iten ther traumatic event, the Medical Examiner.

ZACHARKIN, MAKIA Baltimore, Maryland 21215-0036

Funeral

þ

Be Completed

ဂ

Immediate Cause (Final disease or condition resulting in death)

ations that caused the death. Do i	not enter the mode of dying, such as cardiac or respiratory arrest
Bransten	himorrhage
Due to (or as a consequence	
Due to (or as a consequence	of):

20b. Place of Disposition (Name of cemetery, crematory or other place)

Green Mount Crematory

6500 York Road

Approximate Interval Between Onset and Death Due to (or as a consequence of):

Julia

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5-7-07

22 Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc.

6125 N. Charles St. Baltimore, Maryland

Sequentially list conditions, immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

9 Unknown

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4☐Pregnant at time of death 9 Unknown

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

3 Ectopic pregnancy 5 ☐ Other (specify)

23e. Did tobacco use contribute to the cause of death?

Day

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	10103 20	110 OLI (OSAS) 4 LONATONI
	24a. Was an autopsy performed? 1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
26. Place of Death (Check only one)	

23d. Date of delivery

Month

25. Was case referre examiner? 1 ☐ Yes 2 ☐ N	
27. Manner of Death	
1 Natural	5 Pending investiga
2 Accident	investiga

Hospital: Inpatient 28a. Date of Injury (Month, Day Year) 5 ☐ Pending investigation 6 Could not be determined

Michocki

1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

19a. Informant's Name/Relationship (Type. Print)

Andrew Michocki

21. Signature of Funeral Service Licensee

23a. Part1. Enter the disease, or complications shock, or heart failure. List only one

20a. Method of Disposition

2 ER/Outpatient 3 DOA 28b. Time of 1 TYes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

Reg. No.

Zacharkiw

Baltimore, Maryland

20c. Location - City or Town, State

Baltimore, Maryland

21212

2. Date of Death

29a. Certifier

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifie

29c. License number

29d. Date signed (Month, Day, Year)

Location (Street and Number or Rural Route Number, City or Town, State)

use of death (Item 23a) (Type, Print) 30. Name and address of person who completed

Vie 31. Date filed (Month, Day, Year) 08

than 32 Registrar's Signature

State Registrar

nours after death.

neral Director: A
filled in by the fu

within 24 hours af **To the Funeral D** completely filled in

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 2007 Khalil 4 Afsharzanjani 20 15:45 M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery General Hospital Olney Montgomery If Under 24 Hrs. Hours Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 ☐ F Months Days 77 Director 216-23-3382 3/21/1930 Iran Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show ns 23a or 28a-f shov must be notified at Md. Montgomery 1 ☐ Yes 2X No Director Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18920 Montgomery Village Ave. 20879 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ Specify: white 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) unemployed 8 none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mohammad Afsharzanjani Ahoo ဨ Afsharzanjani 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20879 item 27 i Rasoul Afsharzanjani-son 18920 Montgomery Village Ave. Gaithersburg, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If its any Injury or o 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State All Souls Cemetery 4/24/07 Germantown, Md. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Universal Mortuary 21. Signature Funeral Service Licensee 411 Kennedy St., N.W. Washington, DC 23a. Part1 Enter the lisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** o months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any leading to include cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consuctionox of) Examiner iding physician and burial-trar resulting in death) Last Due to (or as a consequence of) or Vital Records, P.O. Box 68760. The law requires that the death certificate be Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 2 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed Hematoma 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Rupal Failure cut e 1□ Yes 2 No Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ၉ 1 ☐ Yes 2 X No Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division or Attending 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of contific 29d. Date signed (Month, Day, Year) 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18101 Prince Phillip Dr. Montgomery Gen. Olney, MI Hosp. Md. 20832 31. Date filed Month, Day, istrar's Signatur State 2007 Registrar

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			1 = For Stete Registrer	State	of Maryland		artment of H			ene2 ()	07	Berner	329
	Physici	an	1. Decedent's Name (First, Middle, Last)						2. Date of Death Month	Day	Year	3. Time of	Death
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_	Funeral		5. Social Security Number 6. Sex		7. Age (In yrs. last	birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	,	9. Birtho	olace (State o	or Foreign
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	and w.		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Lo	cation					0d. Inside C	ity Limits
	Maryl -f sho	to	Maryland Frederic	ζ	Tiam	svi1	1 _e						2 No
	r 28s	lrec	10e. Street and Number	.•	- J 411		10f. Zip Code		10	g. Citizen of W	/hat Cour	Λ	
	death with the Maryland me 23e or 28e-f show rmust be notified at	Funeral Director	5206 Fairgreene Way	7			2175	4		U.S	.A.		
	tems	uner	77	Armed F		13.	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		- Americk, White,	an Indian, etc.	
36	be filed within 72 hours after death with the Marylan lat Hygiene. id other than "natural", or Items 23s or 28s-1 show avent, the Medical Examinar must be notified at	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □Yes If Yes, G Year or [24∑ No ive Dates:		1 □ Yes 🛣 No	Specify:		Specify:	Wh	ito	
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215	within 72 ene. than "nat	Completed	(Specify only highest grade Elementary/Secondary (0-12)		1-4or 5+)	life.	kind of work done of OO NOT use retired)	king			•	
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and		Be	17. Father's Name (First, Middle, Last) Karl Russell Phill	rick				Florence	e (First, Middle, M	a <i>id</i> en <i>Sum</i> ame	э)		
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	12 h a 7 l s		William Armstrong,							,	5,410, 270	0000)	
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Baltimore,	permit. Pag Department Important: f eny injury o		21. Signature of Furnial Service Limitse	Tell	zer 4		Name and Addres DBERT E.		SON FUNE	RAL HON	MES,	P.A.	
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	uted ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	(or as a consequenc	ce oi):		-					
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X Q Q	eath certifi ettending i for use as	ician/Me	in the past 12 months?	1 Live	birth 2 Fetal dea nant at time of death		Ectopic pregnancy Other (specify)			23d. Date Mon		•	Year
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ρ, J	requires thet the de een signed by the e hould be detached f	by P	Part II. Other significant conditions con	ributing to d	leath but not resulting	g in the ur	nderlying cause give	n in Part I.	23e. Did toba	cco use contri	bute to th	e cause of d	eath?
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_	That are	S			10				perform	ed? de	eath?		
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ö		٦. ٢	1 Yes 25 No.	28a. Date	fnpatient 2 ☐ ER/ of Injury 28t	Outpatien Time of	t 3 DOA 28c. Injury Work	4 🗆 Huising Fic	ome 5 siden 28d. Describe hov			/)	
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UIVISION		Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place build	of Injury - At home, ing, etc. (Specify)	farm, str	eet, factory, office		28f. Location (Stre City or Town,		r or Aura	l Route Num	ber,
	pspita hours uneral y fillec	60	29a. Certifier Certifying Phys	cien: To the	best of my knowled	lge, death	occurred at the tim	e, date and place,	and due to the cau	se(s) and man	ner as st	ated.	
	To the Hospital or within 24 hours after to the Funeral Dir completely filled in	Medic	one)	er: On the b	pasis of examination iner stated.	and/or inv	estigation, in my op	inion, death occur	red at the time, dat	e and place, a	nd due to	the cause(s)
)	To To Con	Σ	29b. Signature and title of certifier	7/	111	_	29c. License		290	1. Date signed	(Month,	Day, Year)	
,	1		10 North Ally	UNI	THEM	0	23	3/05	Cep.	rel d	4,0	700	7
	+		Al, J. AFra	okto	se of death (Item 23)	a) (Type,	+91250	reet,	Frea	erick	4	MD	
	Sta Registr		31. Date filed (Month APR POR) 5 2	007 32. F	Astrar's Signature	X A	back				-		

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ORIGINAL

			1 - State of Maryland / Department - State of Maryland / Department - Certificate			iene _{eg. No} 2007	14830
	Dhusisi		Decedent's Name (First, Middle, Last)		Date of Deat Month	h	3. Time of Death
Service .	Physici /Media		William Lewis Brown			23, 2007 Year	6:54 a.™
	Examir	er		own, or Location of Death		4c. County of Death	
				ince Frederi		Calver	
П	Funeral Director			Days Hours Min.	8. Date of Birth (Month, Day, July 21	Year) 9. Birthp	lace (State or Foreign htry) Ch Carolina
-			Usual Residence of Decedent		July 21	, 1934 Sout	II Caronna
	ırylan show	_	10a. State 10b. County 10c. City, Town or Location			1	0d. Inside City Limits
	ne Ma 8a-f s	Director	MD Calvert Prince Frede				1 ☐ Yes 2 MNo
	with th		10e. Street and Number 470 West Dares Beach Road # 101	ode 0678	1	0g. Citizen of What Coun U.S.	*
	eath is 23	Funeral			ecify Vee or No.	14. Race - Americ	
(0	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examiner must be notified at		1 □ Never Married 2 🔀 Married 1 😭 Yes 2 🔲 No	nt of Hispanic Origin? (Spo y Cuban, Mexican, Puerto	Rican, etc.)	Black, White,	
<u> </u>	ours a ral", c Exan	d b	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: 1953–56 1 ☐ Yes 2 ◘	X No Specify:		Specify: wh	nite
2-0	be filed within 72 hours after death with the Marylan ttal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's Education 16a. Decedent's Usual ((Specify only highest grade completed) (Give kind of work	done during most of work	ing	16b. Kind of Business/Ind	dustry
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d 2	filed Hygin Sther Sent, the	ပိ	11 cabinet ma	18. Mother's Name	e (First, Middle, M	self employ	yea
Maryland 21215-0036	2 should be filed w and Mental Hygie Is marked other ti raumatic event, th	To Be	Ralph Jefferson Brown	Kathr		Robinson	
ary	ges 1 and 2 should it of Health and Men If item 27 is marke or other traumatic		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (S	Street and Number or Rura	al Route Number	City or Town, State, Zip	Code) 20678
Σ	1 and 2 Health tem 27 l			ares Beach R	Rd., #10	1, Prince Fi	rederick,MD
Baltimore,	Pages 1 nent of He int: If iten		20a. Method of Disposition 20b. Place of Disposition (Name cemetery, crematory or other	er place)		20c. Location - City or To	
Ξ	: Pag tment tant: jury	1	4 □ Donation 5 □ Other (Specify) MD Veterans Cer			Cheltenham,	
Ba	permit. Page Department of Important: If any injury or once.		21. Signal of Funeral Service Licensyl 22. Name and A 8325 Mt.	Address of Facility Rau • Harmony La	sch Fund ne, Owi	eral Home, Ings, MD 2073	P.A. 36
в			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line.	of dying, such as cardiac of	or respiratory arre	est,	Approximate Interval Between
	Physician (9 1	Immediate Cause (Final disease or condition a. chronic obstructive puresulting in death)	lmonary dise	ease		Onset and Death
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ğ	w require been sig should b				1 X Ye	s 2 No 3 Prob	ably 4 □Unknown
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/Ita	clan: sertific setor,	Be (25. Was case referred to medical examiner?	26. Place of Death			
0	Physi this o	2	1			nce 6 Other (Specify)
	Attending Physician: r death. ector: After this certific by the funeral director,	io	1 Natural 5 Pending (Month, Day Year) Injury	c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe ho	w injury occurred	
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5	7 9 7 -	Certification	4 Homicide determined building, etc. (Specify)		City or Town	, State)	·
	To the Hospital of within 24 hours af To the Funeral D completely filled it	edical (29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at 2 Medical Examiner: On the basis of examination and/or investigation, in and manner stated.	the time, date and place, n my opinion, death occurr	and due to the cared at the time, da	use(s) and manner as state and place, and due to	ated. the cause(s)
	To the within To the comp	Me	// X //	icense number	29	d. Date signed (Month,	
			Fills Over De	40370		April 24,	2007
K	1.1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)				20672
2	+1		Peter L. Wisniewski, M.D., 110 Hospital Rd. 31. Date filed (Month, Day, Year) 32. Registra's Signature		nce Fre	derick, MD	20678
	Sta Registr		APR 2 4 2007)				

State Registrar 31. Date filed (Month, Day, Year) APR 2 4 2007

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of certifier

person who completed

od address

29c. License number

Type, Print) Doinder

45660

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Deil 23 Day **Physician** Lewis Baston tom 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Medical REGIONOS 59/156414 Hicomios If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 10-17-5 Birthplace (State or Foreign Country) **Funeral** 1 M 2□F Days 218-48-8028 Hours Director MARYLAND Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland alth and Mental Hygiene.
77 is marked other than "natural", or items 23a or 28a-f show ar traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Ma Wicomico SALISBURY Yes 2 No Director 10e. Street and Number 10g, Citizen of What Country? 2 8 UNITED STATES Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No
If Yes, Give
Year or Dates:/969 ~ /97/ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: BLACK Specify. þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) SHORE CAB CO. Elementary/Secondary (0-12) College (1-4or 5+) 12 CAB DRIVER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental BUSTON EVELYN BOSTON obert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 213 Naylor Mill Rd. Salisbury, md 21801 SPENCER CRYSTAL Department of Health Important: If item 27 any Injury or other tr /daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4-30-07 Beulah, Maryland Maryland Veterans Cem. 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Bennie Smith
FUNERAL Home Sign Time Funeral Service Licensee 917 W. Isabella Street SAlisbury md 2180 Approximate Interval Between Onset and Death 2 G)K C 23a. Part1. Emet the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure, List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) erebrovaccular Accident Physician WKS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off requires that the death certificate be executed burial-tran Due to (or as a consequence of): Records, P.O. Box 68760. Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy φ in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Vital 2 No 1∐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA this Division or 28a. Date of Injury (Month, Day Year) 27. Manner Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ignature and litle of certifier D0064152 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1340 S Division St, Ste. 301, Salisburg

Registrar

State

31. Date filed (Month, Day, Year)

APR 25

2007

32. Registrar's Signature

			For	State of Maryla			Health and M	•	_	11000
			1 - State Registrar		Ce	rtificate of	Death	Reg	g. No. 2 U U /	4833
	Physic /Medi		1. Decedent's Name (First, Middle, La ROBERT L	EON BRY	AN			2. Date of Death Month	Day Year 2 200	3. Time of Death 7 645 AM
).	Exami		4a. Facility Name (If not institution, given	ŕ		4b. City, Town,	or Location of Death		4c. County of Dea	th
			13763 Shallcro				dyville	,	Kent	
	Funeral Director		1	Sex 7. Age (In yrs 1	. last birthday, Yrs.	Months Days	r If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 1) Aug 8 1	year) 9. Bir 915 Mar	thplace (State or Foreign ountry) yland
	yland		10a. State 10b. County	10c. C	ity, Town or L	ocation				10d. Inside City Limits
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	or 28	Dire	10e. Street and Number	1	_	10f. Zip Code		10	g. Citizen of What Co	ountry?
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Maryland 21215-0036	72 hours after death with the Maryland "naturel", or Items 23a or 28a-f show idical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in the Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cui	Hispanic Origin? (Sp ban, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify:	
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7	Hygier Hygier ther th	ဝိ	17. Father's Name (First, Middle, Last	5	Che	emical	Engineer		Manufact	uring
anc	호 를 <mark>충</mark> 중	Be	Leon O. Bryan	7			Irene	e (First, Middle, Ma Raird	aiden Sumame)	
2	2 should and Men is marke eumatic	ဥ	19a. Informant's Name/Relationship	(Type, Print)	19h Maili	ng Address (Stree			City or Town State	Zip Code) 21645
	d 2 th a		Robert L. Brya	** '						dyville MD
Je,	Pages 1 en nent of Heal snt: if Item 2 sry or other		20a. Method of Disposition	20b.		osition (Name of matory or other pla			c. Location - City or	
Ē	Page nent c ant: if		1 ☐ Burial 2 【*** Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control Contr	77.		remation		/07	Smyrna,	DE.
Baltimore,	permit. Page Department of Importent: if any njury or once.		21. Signature of Fune al Service Uto	M00	510 1	Name and Addr Salena I 18 West	Funeral E Cross	Home of	Stephen	L. Schaec 21635
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the dea	th. Do not en	ter the mode of dy	ing, such as cardiac o	or respiratory arres	it,	Approximate Interval Between
я	Physician		Immediate Cause (Final disease or condition	. CONGES						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):					- 20043
	Lxammer	<u>_</u>	Sequentially list conditions,	. ATRIAL		CILLAT	10/V			3 days
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ν -	e be executed sicien and burial-transit	Exar	that initiated events resulting in death) Last	c. Due to (or as a conse	quence of):					
760,	ysicie buri	cail		d						
68	tificat ng phy as th									
Box	th cer lendir r use	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr		Ectopic pregnanc	N.		23d. Date of del	ivery
Ö. E	The law requires that the death certifica sie has been signed by the ettending ph page 2 should be deleched for use as th	Completed by Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of		Other (specify)	· y		Month	Day Year
P.O.	hat th d by (Ph	9 ☐ Unknown Part II. Other significant conditions of		multipa in the	-4-4-4		00- Diday	1	
ds,	signe d be d	d b	PNEUMONIA		sulling at the u	ndenying cause gi	ven in Parti.			the cause of death?
Sor	he law require s has been sig ge 2 should b	etec	GENERAL FRA		110 = -	D'THO	V/E	-		
Rec	The lav	g	·	TICITY PITC	ure	117/21	V =	24a. Was an autopsy performe	prior to	lopsy findings available completion of cause of
ā		e Co	25. Was case referred to medical					1 ☐ Yes 2 🔀		2 X No
Š	Physicien: r this certific ral director,	To B	examiner?	Hospital: 1 Inpatient 2	TEB/Qutnatier	nt 3 DOA Ot	26. Place of Death		ce 6 ∐Other (Spe	-4.1
5	g Ph ter thi		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o	7 74 15 1		28d. Describe how		City)
Ö	Attending in death. ector: After by the fune	atio	t Natural 5 ☐ Pending 2 ☐ Accident investigatio	n	Injury		Yes 2 No			
Division of Vital Records,	in Pitte	Certification;	3 Suicide 6 Could not b 4 Homicide determined		nome, farm, str	eet, factory, office		28f. Location (Stree City or Town,	et and Number or Ru State)	iral Route Number,
	To the Hospital within 24 hours a To the Funeral completely filled	Medicai	(Check only one)	nyaician: To the best of my kn miner: On the basis of examin and manner stated.	owledge, deat ation and/or in	n occurred at the treestigation, in my	ims, date and place, opinion, death occurre	and due to the caused at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
0	To th within To th compl	Me	29b. Signature and title of certifier	11.0		I	se number	1	. Date signed (Monti	h, Day, Year)
			> Am A/	wince mi		DO	04158	7	5/2/	2007
	. –		30. Name and address of person who				3.44	1		
	15		Helen A. Noble		-	r Rd. C	hesterto	wn, MD.	21620	
	Sta Registr		31. Date filed (Month, Day Year)	32. Registrar's Sign	ature	0				

DHMH 17 Rev 1/2001

Registrar

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) MILDRED ELIZABETH COOKE 04 19 2007 0728 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death UNIVERSITY OF MARY LAND MEDICAL CENTER BAITIMORE Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) . Social Security Number 7. Age (In yrs. last birthday) Hours 1 ☐ M 2 🗓 F 23, 1920 Washington, DC 86 Oct. 579-16-8238 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 □Yes 2 TNo Maryland Talbot Easton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21601 28515 Augusta Court 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No Specify: Specify: White 3 ₩ Widowed 4 Divorced 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 University Administrator University of Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph Alexander Geier Mary Elizabeth Wagner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10708 Amherst Avenue, Silver Spring, MD 20902

Date | 20c. Location - City or Town, State Lara Cooke Morford/Granddaughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition N☐ Burial 2 ☐ Cremation 3 ☐ Removal from State April 25, Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2007 Silver Spring, Maryland

permit. Pages 1 and 2.
Department of Health an.
Important: If them 27 is m. any injury or other **Physician** /Medical Examiner

and

nding physician

certificate be executed

Division or Vital Records, P.O. Box 68760

Physician

/Medical

Examiner

Funeral

Director

be filed within 72 hours after death with the Maryland ntal Hygiene.

Baltimore, Maryland 21215-0036

"natural", or items 23a or 28a-f show dical Examiner must be notifled at

traumatic event, the Medical

Director

Funeral

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	21. Signature of Funeral Service License	Dan Son	Franc	cis J. Collins			
	23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	cations that caused the death. Do not e cause on each line.	t enter the m	Jniversity Blv ode of dying, such as cardiac	or respiratory a	Silver Spri	pproximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of)	TD	IS EASE			Offiset and Death
miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underships Cause (Disease or injury that initiated events	Due to (or as a consequence of)	:				
lical Exar	resulting in death) Last	Due to (or as a consequence of)	i.				
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □Ectopic 5 □ Other			23d. Date of de Month	elivery Day Year
ed by Ph	Part II. Other significant conditions con	tributing to death but not resulting in th	he underlyin	g cause given in Part I.		tobacco use contribute t Yes 2 □ No 3 □ P	
omplete					24a. Was auto perfo 1∐ Yes	psy prior to death?	utopsy findings available completion of cause of s 2 \sum No
Be C	25. Was case referred to medical			26. Place of Dea	ath (Check only	one)	
	examiner? 1 ☐ Yes 2 ☐ No	lospital: 1 Inpatient 2 ER/Outp	atient 3	DOA Other: 4 Nursing H	lome 5 ☐ Res	idence 6 □Other (Spe	ecify)
ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Tin Inju		28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe	how injury occurred	
Medical Certification: To	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At home, farm building, etc. (Specify)	n, street, fac	tory, office	28f. Location (City or To	(Street and Number or F wn, State)	lural Route Number,
edical (29a. Certifier 1 Certifying Physical Check only one) 2 Medical Examination	sician: To the best of my knowledge, oner: On the basis of examination and/and manner stated.	death occurr or investigat	red at the time, date and place tion, in my opinion, death occ	e, and due to the urred at the time	cause(s) and manner a , date and place, and du	us stated. ue to the cause(s)
Ĭ	29b. Signature and title of certifier			29c. License number		29d. Date signed (Mon	ith, Day, Year)

State

within 24 hours after death

To the Funeral Director:

To the Hospital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

EYVAZZADEH

Day, Year)

31. Date filed (Mo

A44176435E16775 04/19/2007

22 SOUTH GREENE ST, BALTIMORE, MD 21201

State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend #26 per Phys/Fh 04-25€200 Tate of Death CNM Rea. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** April 20, 2007 3:27 p. May Ruth Chapman /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 35 Jeffrey Lane Brunswick Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Months 1 ☐ M 2 🙀 F 70 Yrs. Director 174-30-5058 May 6, 1936 Pennsylvania Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 28a-f show traumatic event, the Mudical Examiner must be notified at 1 ¥Yes 2 No Maryland Frederick Brunswick Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö 35 Jeffrey Lane 21758 IISA or Items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. e tiled within 72 hours after all Hygiene.
I Hygiene. 1 ☐ Yes 2 →No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 Yes 2 No Specify: Specify: þ If Yes, Give Year or Dates: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4 Minister Religion 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 should be to and Mental H George W. Heiser Ruth Amelia Dersch 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) of Health an Linda Beall- daughter 35 Jeffrey Lane, Brunswick, Maryland 21758 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Depertment of Ho
Importent: If Iter
any Injury or oth 1 Burial 2 Tremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Stauffer Crematory 4-23-2007 Frederick, Maryland 22. Name and Address of Facility Stauffer Funeral Home 21. Signature of Funeral Service Ligensee arou Eluc 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final **Physician** End breast cancer with disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner metastases to bone yrs Sequentially list conditions, if any, leading to intribulate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examine ed by the attending physician and detached for use as the burial-transit requires that the death certiticate be executed Hypertension yrs that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Coronary artery disease yrs Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Dav 4☐Pregnant at time of death 5 Other (specify) 9 Unknown sete has been signed by a page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an this certificete has 1 Yes 2 No Hospital or Attending Physician: funeral director Be 25. Was case referred to medical 26. Place of Death | Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home Residence 6 Other (Specify) 29 No 1 Tyes 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred Atter Injury 1 Natural 5 Pending s after dec. 1 TYes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) tilled in by 4 | Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifies cal (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D54749 April 23, 2007 30. Name and address of person who completed cause of death item 23a) (Type, Print) 801 1611 House Avenue, D-1, Frederick, Maryland Allen Reilly, M.D. 31. Date filed (Month, Day, Year) Registrar's Signature State APR 2 5 2007 Spark Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Nellie Frances Coleman APRIL 2007 /Medical 7:32 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CIVISTA MEDICAL CENTER LAPLATA CHARLES 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) 1 □ M 2 🗓 F Months Days Hours Min. Director 218-30-4980 27,1914 August Virginia Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits ortant: If Item 27 is man ed other than "natural" or items 23a or 28a-f show Injury or other traumatic event, the <u>Medical Examiner must be notified at</u> MD Charles Director Mt. Victoria 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14432 Rock Point Road 20661 Funeral USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Bace - American Indian Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married laryland 21215-0036 1 ☐ Yes 21 No þ Specify. Specify: White 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6 Homemaker <u>Home</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and 2 should be ealth and M ntal Rudolph Via James ပ Nancy Frances Walton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ≥ Gloria Robertson/Daughter 8030 Port Tobacco Rd. Port Tobacco, MD Department of Hear Important: If Item 2, any Injury Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 □XBurial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Moriah Methodist Cemetery4/27/07 White Hall, VA 21. Signature of Funeral Service Licensee M00945 2 Name and Address of Facility AREHART-ECHOLS FUNERAL HOME, P.A. 1and 0 Cha 211 St. Mary's Ave. I a P1ata MD 20646. Shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CON GESTIVE HEART ALLUKE EW /Medical Due to (or as consequence of): Examiner ATRIAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 1 No 4□Pregnant at time of death Month Day Year 5 ☐ Other (specify) 2 No 9 Unknowr Part LOther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DINO 1 Tes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autonsy perform 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 Yes 2NNo 1 Inpatient 2 R/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury at 28d. Describe how injury occurred Certification; 5 ☐ Pending investigation in 24 hours area control the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3□ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D- 44436 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ASHVIN PATEL 102 PAUL MELLON COURT SUITE 102 WALDORF, MD 20602-2793 31. Date filed (Month, Day, Year) 32. Resistrar's Signature State APR 25 200 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra AMEND#1, perMD, 4/25/07, DES, McCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2007 Month **Physician** Fortunato DeLima Manoel Fortunato DeLima 19, April 10:55 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Holy Cross Hospital Social Security Number 6. Sex Montgomery

9. Birtinplace (State or Foreign Country) Silver Spring
If Under 1 Year 1 of Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1X M 2 F Yrs. Director May 27, 1927 Brazil 79 214-33-3206 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

nnt; If Hem 27 is marked other than "natural", or Hems 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 ☑ No ns 23a or 28a-f sh must be notified Directo Maryland Silver Spring Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number or items 23a Funeral 9605 Clearview Place 20901 USA 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Błack, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 24 ☐ No Specify: Specify: White ģ 3 ☐ Widowed 4 💆 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Brick_Layer Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sebastiana dos Reis Campos ပ Joaquim Fortunato de Lima 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20226 Lea Pond Place, Montgomery Village, MD 20886 Loide Maranho/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State April 21 permit. Pages Department of Important; If It any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2007 Metropolitan Crematory Alexandria, Virginia 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. مكحك MD 20901 S 500 University Blvd, W., Silver Spring, ames 23a. Part1. Enter the disease, or complications that caulled the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Acute Cerebrovascular Accident disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and the burial-trar Due to (or as a consequence of): cate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Chronic Obstructive Pulmonary Disease 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perforn certificate XXNo funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 X Inpatient 2 ☐ ER/Cutpatient 3 ☐ DOA 1 ☐ Yes ZZ.No Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After Injury 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident within 24 hours after death To the Funeral Director: the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760, or Attending Physician:

Baltimore, Maryland 21215-0036

completely J

> State Registrar

31. Date filed (Month, Day, Year) APR 24

29b. Signature and title of certifier

29a. Certifier

(Check only one)



and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D32817

29d. Date signed (Month, Day, Year)

April 19,

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** George William Doyle, Sr April 2007 5:15p ^M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Westminster Nursing & Rehab Ctr Carroll <u>Westminster</u> 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthda) **Funeral** M 2 ☐ F Director 251-32-5242 SC Mar 24 1926 Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be r 21157 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must once. 1234 Washington Road USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ Specify: 3 Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Disabled N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Jesse Doyle Estelle Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4515 Oakleigh Dr Manchester, MD 21102
of Disposition (Name of Date 20c. Location - City or Town, State <u>Doris Shillingburg/niece</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/25/2007 Conway, SC Hillcrest Cem 21. Signature of Funeral Service Licen and Address of Facility Pritts Funeral Home and Chapel, P.A. Washington Rd Westminster, MD21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset,and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical (or as a consequence of): Examiner timpse Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): physician a s the burial-1 Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy 5 □ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4□Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ has been sign 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ nknown Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No certificate ha 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ၉ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Medical Certification: 1 🔼 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No thours after death.

uneral Director: A
ely filled in by the fu 2 ☐ Accident investigation 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide vithin 24 hours are To the Funeral Di To the Hospital 29a. Certifier 1 Kcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signatine and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) WIL ++3 30. Name and address of person who cause of death (Item 23a) (Type, MD

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day,

APR 2

2007

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registre Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** RUBY DAVTS APRIL 2007 4:40 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** LORIEN @ RIVERSIDE BELCAMP HARFORD If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 1 ☐ M 2 🛛 F 67 Director 088-30-5685 AUG 22, 1939 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28a-f show or other traumatic avent, the Medical Exeminer must be nutified at 1X Yes 2 No Director MARYLAND HARFORD HAVRE DE GRACE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code or itams 23a 800 LAFAYETTE STREET 21078 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 X No Specify: Specify: BIACK 3 X Widowed 4 ☐ Divorced "natural", 15. Decedent's Education 16a. Decedent's Usual Occupation 16h. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) DIATETICS VA HOSPITAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 12 should be fi and Mental H is markad otl ISAAC BROWN EDNA JOHNSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) parmit. Pages 1 and 2 sh Department of Heath and Important: If itam 27 is rr any injury or othar traum MICHELE TOMLINSON / DAUGHTER 411 MAIN STREET, CAHOKIA, ILLINOIS 62206 of Disposition (Name of 20c. Location - City or T 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State `4 ☐ Donation 5 ☐ Other (Specify) 4/26/07 R.A. FERRIS & CO INC. WEST CHESTER, PA 22. Name and Address of Facility 21. Signature of Funeral Service Licenses LISA SCOTT FUNERAL HOME, P.A.

552 LEWIS STREET, HAVRE DE GRACE, MD

shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LARCINOMA LUNG Pnysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Due to (or as a consequence of): the attending physician Box 68760 Physician/Medical the as IF FEMALE esn 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown signed by i Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by Carchomyopalh 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 2∏ No 1 Yes 1 Tyes or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Certification: 1 Satural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Diractor: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours a

To tha Funaral C Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifier Wham 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marre De Gray my 21078 enalutros ST Muhain The 31. Date filed APR 2. Registrar's Signature 2 4 2007 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	9 I E		Decedent's Name (First, Middle, Last)					2. Date of Death	201	ar /	3. Time of Death
•	Physicia /Medic		Myrtle Diggs					April	17 200		2:05A M
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DHMH 17 Rev 1/2001

ORIGINAL

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	/Medi Examir		4a. Facility Name (If not institution,	give street and num	nber)		4b. City,	Town, or	Location	of Death	////		nty of Death		
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	Funeral			6. Sex	7. Age (In yrs. last b.	irthday)		1 Year	If Under	24 Hrs.	8. Date of Birth	1		place (State or Foreign ntry)	
в	Director		222-20-6219	1 □ M 2 x F	72	Yrs.	Months	Days	Hours	Min.	(Month, Day			nnsylvania	
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	Pa-1 s	Director	Maryland Mont	gomery			Silve	er Sp	ring					1 ☐ Yes 2 🛣 No	
	th th)ire	10e. Street and Number				10f. Zip	Code				10g. Citizen o	of What Cou	ntry?	
	72 hours after death with the Maryland natural', or Itams 23a or 28a-f show Great Examiner must be notified at	ä	1517 Lemontre	e Lane				209	04				U.S.A.		
	ams fr	Funerai	11. Marital Status	12. Was Dece Armed For	dent Ever in U.S.	13.	Was Deced	ent of Hi	spanic Ori	igin? (Spe	ecify Yes or No- Rican, etc.)	14. F	ace - Ameri lack, White,		
9	or It		1 Never Married 2 Marrie		2 🗷 No		1 🗆 Yes 2				riidan, etc./			etc.	
8	ours aft ral', or	1 by	3 ☐ Widowed 4 ☐ Divorced	Year or Da			10105 2	AET INO	эрөспу.			Spe	Giry: W	Mite	
21215-0036	be filed within 72 ho ital Hygiene. id other than "natur avent, Ine Medical	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most life. DO NOT use retired)						t of worki	na	16b. Kind of	Business/Ir	ndustry		
7	within ene.	npi	Elementary/Secondary (0-12)	College (1	-4or 5+)	life.	DO NOT us	e retired,)						
7	illed within Hygiene. Other than	Ö		2			Home	emake	r			0	wn Home		
nd	be filk tal Hy doth avent	Be	17. Father's Name (First, Middle, L.	ast)					18. Mothe	er's Name	(First, Middle,	Maiden Sum	ame)		
la	should be nd Menta i marked umatic av	2	James Graham Ste	ewart						Nata1	ie Herbst				
Maryland	01 = - 3		19a. Informant's Name/Relationshi	p (Type, Print)	19	b. Maili	ng Address	(Street a	ind Numbe	er or Rura	l Route Numbe	r, City or Tow	m, State, Zij	Code)	
	and 2 lealth a m 27 is		David A. Ellis -	Spouse	1	517	Lemontr	ee L	ane, S	ilver	Spring,	Marylan	1 20904		
Baltimore,	s 1 ar		20a. Method of Disposition		20b. Place of	of Dispo		e of			ate	20c. Locatio			
E	Pages nent of I int: If its iry or of		1 ▲Burial 2 □ Cremation 3 1 4 □ Donation 5 □ Other (Spe		State Union			nor place		1. /21	/2007	Preston		Marrel and	
量	그 든 뿐 글		21. Signature of Funeral Service Li		W OILON		2. Name and	d Addres	s of Facilit		2007	Burtons	sville,	Maryland	
Ba	permi Depar Impol any ir		Δ	M	X.	Hi	nes-Rin	ıaldi	Funer	al Ho	me, Inc.		3.6		
			23a Part 1 Enter the disease or c	omnlications that ca	sused the death. Do								g, Mary	1and 20904 Approximate	
ы			23a. Part1. Enter the disease, or c shock, or heart fairure. List o	nly one cause on ea	ach line.	not em	100 11100				respiratory arr	est,		Interval Between Onset and Death	
	Pnysician		Immediate Cause (Final disease or condition resulting in death)	_ a	TAILU	RE	10)] [HRII	Vt					
	/Medical Examiner		resulting in death)	Due to (or as a consequence	of):		18000	. ۵ سسا)					
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oʻ	te be executed ysician and le burial-transit		resulting in death) Last	Due to (or as a consequence	of):									
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68		Physician/Med	1												
Вох	eath certific attending p I for use as i	J.	IF FEMALE: 23b. Was decedent pregnant		come of pregnancy	2 5	75-4:					23d. E	3d. Date of delivery		
	deatl	icia	in the past 12 pronths?	4☐Pregna	ant at time of death		JEctopic pre] Other (spe					P	Nonth	Day Year	
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₾.	requires that the een signed by th nould be detache		Partil. Other significant condition	s contributing to de	ath but not resulting i	in the u	nderlying ca	use give	n in Part I.		23e. Did to	bacco use co	ntribute to t	he cause of death?	
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ě	g 25 C	mpi		•						_	24a. Was a autops	Y	prior to co	psy findings available mpletion of cause of	
F	Th ate pag	Co	HUPERTENS	SION							perform	No	death? 1 🗌 Yes	212 No	
/ite	Physician: Th this certificate ral director, pag	Be	25. as case referred to medical examiner?	1					26. Place	of Death	(Check only on	θ)			
of	S S = 5	2	1 ☐ Yes 2 No	Hospital: 1 □ Ir	patient 2 ER/O	utpatier	it 3 DO/	Othe	r 41 Nu	rsing Hon	ne 5 🗆 Reside	ence 6 🗆 O	ther (Specif	y)	
	ding Phy th. After thi funeral o		27. Manner of Death Natural 5 ☐ Pending	28a. Date o (Monti	f Injury 28b.	Time of	28	c. Injury Work	at ?	2	28d. Describe ho	w injury occ	urred		
Division	Attanding or death, actor: After by the fune	ertification;	2 Accident investiga	tion			М		es 2□	No					
<u> </u>	Atta	tific	3 Suicide 6 Could no 4 Homicide determin	ed 289. Place	of Injury - At home, fa	arm, str	eet, factory,	office		2	28f. Location (SI City or Town	reet and Nur	nber or Rura	al Route Number,	
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	To the Hospital or Attand within 24 hours after death To tha Funeral Diractor: / completely filled in by the fi	alc	29a. Certifier Certifying	Physician: To the	best of my knowledg	e, death	n occurred a	t the time	e, date an	d place, a	ind due to the c	ause(s) and r	nanner as s	tated.	
	e Hc a Fu letely	edical	(Check only 2 Medical Ex	caminer: On the ba and mann	sis of examination ar	nd/or in	vestigation,	in my opi	inion, deal	th occurre	ed at the time, d	ate and place	, and due to	the cause(s)	
	To the within 2 To tha Complet	Me	29b. Signature and title of certifier	A			29c.	License	number		2	9d. Date sigr	ed (Month,	Day, Year)	
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	`		30. Name and address of person wi	no completed cause	of death (Item 23a)	(Type,	Print)	1774	A	50	LITTE 2	23 F	SATI	MD 2209	
			1175NEETY) F	ナトノナナ		27	3/1/1	1//	" J V (LIIL	0 3 /1	20146	ا محلی (۱۱۰۰	
	Sta	-	31. Date filed (Month, Day, Year) APR 2 4 2		egistrar's Signature	1	. E .								
	Registr	ar	MPR 24 L	201	400 pg. 1										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 04 2007 Jonathon 23 0528 M Michael Ebv /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NICONOIOS REGIONAL MEDICAL Salisbur Center eninsuca If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) . Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 1**M**M 2□ F Months Days Hours 219-62-8149 54 Director 10/26/1952 Maryland Usual Residence of Deceden 10c. City, Town or Location 10d. Inside City Limits 10h County with the Marylan 10a, State r 28a-f show notified at Yes 2∐No Director MD Somerset Princess Anne 10e. Street and Number 10g. Citizen of What Country? ral", or items 23a or Examiner must be I 30491 Pecan Drive 21853 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. ould be filed within 72 hours after Mental Hygiene. Never Married 2☐ Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify þ 3 ☐ Widowed 4 ☐ Divorced White "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical College (1-4or 5+) than Elementary/Secondary (0-12) 12 Electricans Helper Electrical none 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Be Martin Eby Josephine Evans ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 any Injury or other tr 30402 Pine Street, Princess Anne, MD 21853 Josephine Eby/Mother Baltimore, 20a. Method of Disposition

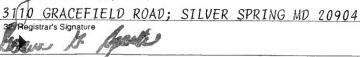
1 ☑ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ᇹ Quinton Cemetery 04/27/2007 | Pocomoke City, MD 4 Donation 5 Dother (Specify) Signature of Funeral advice Licensee 22. Name and Address of Facility Hinman Funeral Home M00295 111673 Somerset Ave., Princess Anne, MD 21853 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Acute Respiratory Immediate Cause (Final Failure Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Lancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the death certificate be executed abuse Tobacco Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. Completed by The law requires OPD. 2 No 3 Probably 4 Unknown rabetes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 2□No 1 Yes 1⊟ Yes 2**X**No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 3 Suicide 6 □ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide hours after within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D63499 and address of person who completed cause of death (Item 23a) (Type, Print) ElmStreet Princess Anne MD 21875 WILSON Nino 31. Date filed (Month, Day, Year) 32. Registar's Signature State 2007 Registrar

			1 - For State Registrar	State of Ma	iryfand / [mént of I ficate of	dealth and N Death	Mental H	ygier Reg. N	CU	07	14845		
			1. Decedent's Name (First, Middle, Las	t)					2. Date of D	Death			3. Time of Death		
Н	Physic /Medi		GOLDIE G. FELDMAN	1					APRIL	22	2007	Year 7	4:16 A M		
	Exami		4a. Facility Name (If not institution, give	street and number)		4	b. City, Town,	or Location of Death		4	4c. County of Death				
			HOLY CROSS HOSPIT	AL			SILVER S	SPRING			MONTG	OMER	/		
	Funeral Director		- 055 - 074487	ox □M 2X1F	(In yrs. last bir		f Under 1 Year fonths Days	If Under 24 Hrs. Hours Min.	8. Date of E (Month, L 11/27	Гау, Үва		9. Birtho Cour NEW			
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Loca	ion					1	0d. Inside City Limits		
	Mary	ō	FLORIDA PALM B	BEACH	В	OCA R	ATON						1 ☐ Yes 21 No		
	r 28s	Director	10e. Street and Number				10f. Zip Code			10g. C	Citizen of V	What Cour	ntry?		
	h wit)		1024 CORNWALL BLV	$^{\prime}\mathcal{D}$			33434				USA		•		
	deat ms	Funerai	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. Wa		Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or N		14. Race	e - Americ			
900	within 72 hours atter death with the Maryland ane. then "natural", or Items 23e or 28e-f ehow the Modical Exertinal must be notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐XNo			Yes 2DXNo		Hican, etc.)			ck, White, v: WHI7			
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2	nen.	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	life. DO	NOT use retire	d)	9						
7	7		17. Father's Name (First, Middle, Last)				MAKER	40.04.4.4.0			OWN HOME				
/land	B a b y	To Be	17. Father's Name (First, Middle, Last)	UKN				18. Mother's Nam	θ (First, Middi	e, Maide	n Sumam	[™] UKN	I		
Maryland 21215-0036	nd 2 should aith and Men 27 le marke ir treumatic									Rural Route Number, City or Town, State, Zip Code) APOLIS MD 21403					
Baltimore,	Pages 1 and nent of Healt out: If item 2 ary or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify,		20b. Place of cemeter	Dispositi y, cremat		Ce)	Date 4/2007	20c.	Location -	•			
aĦ	in part		21. Signature of Funeral Service Licensee 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME												
<u>m</u>	Per Per Per Per Per Per Per Per Per Per		Megelin T, y	Webers		118	00 NEW	HAMPSHIRE	AVE.;	SIL	VER	SPRIN	IG MD 2090		
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ı	/Medical Examiner		(Southing Wir Goddin)		Consequence		CIDOTAL	10011110	TOFIO						
		ē	Sequentially list conditions, if any, leading to immediate	b. ATHEREROSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of):											
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ó	ificate be executed g physicien and as the burial-transit		resulting in death) Last	Due to (or as a	(or as a consequence of):										
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.O. Box 6	death certif e attending d for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) Month									ry Day Year		
α.	that hed by deta	F.	Part II. Other significant conditions con	ntributing to death bu	t not resulting in	the unde	tying cause giv	en in Part I.	23e. Did	tobacco	use contr	ibute to th	e cause of death?		
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ecol	The law requires that the site has been signed by the bage 2 should be detache	Completed	DIABETES MELLIT	US					24a. Was	s an	24b. W	Vere autop	psy findings available		
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On	ding After fune	ation	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day		jury	28c, Injur Wor M 1	yat k? Yes 2 □No	28d. Describe	how inju	iry occurre	эd			
Division of Vital Record	A P S S	Certification:	3 Suicide 6 Could not be 4 Homicide determined	m, street,	factory, office		28f. Location City or To	(Street a	nd Numbe	nd Number or Rural Route Number, a)					
	To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by	Medicai C	29a. Certifier (Check only one) 1 Certifying Physical Examination	sician: To the best of ner: On the basis of and manner state	examination and	death oc	curred at the ting gation, in my o	ne, date and place, pinion, death occurr	and due to the	cause(s	and mar	nner as sta ind due to	ated. the cause(s)		
	To the within 2 To the complet	Me	29b. Signature and title of certifier	/ -			29c. Licens	e number		29d. Da	ate signed	(Month, E	Day, Year)		

State Registrar

31. Date filed (Month, Day, Year) APR 2 4 2007

JOHN STUCKEY M.D.



D23649

4/22/2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

ies D. Frazie	1	- For State Control of Peat Registrar Certificate of Deat	h	Reg. N	lo. 24	0/1404
Physicia	ın/	1. Decedent's Name (First, Middle,Last) James David Frazier		2. Date of Death Month Da May 1, 2007	y Year	3. Time of Death 2153 hrs
Examin		-	Town, or Location of Death		4c. County of Death Montgomery	1
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Und	er 1 Year If Under 24Hrs.	8. Date of Birth(M	M/DD/YYYY) 9. Bir	
Director		217-04-5546 1XM 2F 31 Yrs. Month	ns Days Hours Min.	Nov. 3,	1975 cc	ount@eorgia
any	- 1-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	D. 41 1.			10d. Inside City Limits 1 Yes 2 No
·land -f show	to	1,22) 23.1	Bethesda Code	10g.	Citizen of What Cou	2.4-
the Mary a or 28a tiffed at	Director	5824 Inman Park Circle	20852	2 .	U.S.A	•
ath with the Maryland items 23a or 28a-f show ist be notified at once.	Funeral	1 Never Married 2 X Married Armed Forces? If Yes, speci	ent of Hispanic Origin? (Sp ify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer White, etc.	rican Indian, Black,
after de	by Fu	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2	No specify:		Specify: W	hite
hours a	ted b	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual during most of wo	l Occupation (Give kind of working life. DO NOT use retire	red) r	Technolog	y Consulting
5-0036 led within 72 Hygiene. to ther than '	Completed	4 Project Mar	_		Company	
15-0 filed wall Hygic ed othe	Be Co	17. Father's Name (First, Middle, Last) David John Frazier	Nancy El		Higginbot	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importment: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	ToB	19a: Informant's Name/Relationship (Type, Print) Lisa Marie Oltmanns-Frazier/Wife 5824 Ir	s (Street and Number or F	Rural Route Numbe	r, City or Town, Stat Bethesda,	e, Zip Code) MD 20852
e, MD 1 and 2 sho Health and item 27 is		20a Mathod of Disposition (Na	ame of cemetery,	Date 2	0c. Location - City o	or Town, State
Baltimore, permit. Pages 1 ar Department of Hee Important. If ite		1 Burial 2 X Cremation 3 Removal from State crematory or other place 4 Ponation 5 Other Specify:	CONTRACTOR OF THE SAME	5, 2007	Smithsbur	g, Maryland
Balti permit. Departi Importi injury		MO0021 Keer	d Address of Facility ney and Basfo	ord Funer	al Home	VD 01701
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.		njest	PLE FILLER	Between Onset and
Medical aminer	St 3	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	ular Disease			Death
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kecuted the rand		events resulting in death) Last Due to (or as a consequence of): d.				
50, te be execut sysician and burial - trai	Wedical	UNPENDED AMENDED			23d. Date of delive	on,
1876(tificate ing phy as the b	an/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal deat	h 3 Ectopic pregna	ancy	Month Month	Day Year
Records, P.O. Box 68760, The law requires that the death certificate be executed icate has been signed by the attending physician and page 2 should be detached for use as the burial - transi	Physician/	1 Yes 2 No 9 Unknown Pregnant at time of death 5 Other (Sp	necify)			
.O. E hat the c ed by th etached	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying	ng cause given in Part I.			to the cause of death?
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on of ording F. After refrence	ion:	1 Natural 5 Pending (Month, Day, Year)	1 Yes 2 No			_
Division of Vital Records, P.O. Box 6876 To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death. To the Funeral Direct After this certificate has been signed by the attending phycompleapy filled in by the funeral director, page 2 should be detached for use as the	Medical Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factor (Specify)	ory, office building, etc.	28f. Location (Str or Town, Sta		Rural Route Number, City
E Hospita 24 hours F Funera	al Ce	4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at 1 (Check only	the time, date and place, an	id due to the cause	(s) and manner as s	tated. the cause(s)
To the Hos within 24 h To the Fina completely	Medic	ally flatillet stateu.	29c. License number		29d. Date signed (/	
		Januar Drusthall, mis	O.C.M.E.	_	May 2, 2007	
AC		30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Per	nn Street, Baltimore,	MD 21201		
	tate	31. Date filed (Month, Day, Year) 37 Registrar's Signature				
Regi	stra	MAY 0 8 2007 Blows S. Apart				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) April 21, 2007 **Physician** Diane Delores Gordon 2:10 a /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Carroll Westminster Dove House Carroll Hospice 9. Birthplace (State or Foreign Country) MaryLand 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 9, 1946 6. Sex 5. Social Security Number **Funeral** Days Min. 1 M 2 KF Months Hours Yrs. 60 Director 220-42-8960 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County items 23a or 28a-f ehow Pages 1 end 2 should be filled within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
sent of Health and Mental Hygiene.
sent: If items 27 le marked other than "naturel", or litems 23e or 28a-1 ehow usy or other treumatic event, it is wed real Exeminan must be notified at Randallstown 1 ☐ Yes 2 X No Maryland Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21133 3902 Amy Lane USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No ff Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Black 3 ☐ Widowed 4 ☑ Divorced Completed by 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Telephone Company 12 Sales Consultant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Clarissa Keyes Vennard Wilkins, Sr. ပ္ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3902 Amy Lane, Randallstown, MD 21133 Keith A. Gordon, son 20b. Place of Disposition (Name of cametery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State permit. Page Depertment o Important: If eny injury or once. 04/23/2007 Winfield, MD 4 □Donation 5 □ Other (Specify) Carroll Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M01191 Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157 23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetaf death 23b. Was decedent pregnant 23d. Date of defivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a Id be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Ves 2 □ No 3 Probably 4 Unknown Completed peen 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No s certificete hes t lirector, page 2 s 2 1 No 1 ☐ Yes or Attending Physicien: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၀ 3□ DOA this funeral 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? (hosper) Certification: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death investigation 2 Accident illed in by the Director 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or At within 24 hours efter of To the Funerel Direct 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

DHMH 17 Rev 1/2001

State

Registrar

Name and address of person

24

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

th Couter Street Livestminster

who completed cause of death (Item 23a) (Type, Print)

32. Redistrar's Signature

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	Funeral Director		5. Social Security Number 213–16–4899 6. Sex 1 1 1 M 2 □ F 7. Age (In yrs. 86	. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 12/23/192	Year)	Count	ace (State or Foreign try) ISYLvania	
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	a-f sho	ctor	MD Baltimore	Coc	keysville	2			1 □Yes 211 No		
	with the	I Dire	10e. Street and Number 15 Ivy Hill Court		10f. Zip Code 21030)	10	10g. Citizen of What Country? USA			
2-003p	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatin and Mental Hygiene. Important: if tiem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	d by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in Uarmed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates: WWT	I I	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2☐¶No	Specify:		Spec	ace - America ack, White, e hify: Whit	etc. CE	
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Mary	d 2 sho th and th 7 Is ma trauma	·	19a. Informant's Name/Relationship (Type. Print) Betty Contino/Daughter	1	ng Address <i>(Street :</i> Ivy H ill					`	
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	To the within To the compl	Me	29b. Signature and title of certifier		29c. Licens	61199		_	ned (Month,	Day, Year) 2007	
•	V		30. Name and address of person who completed cause of death (Ite	em 23a) (Type,							
*	Sta	at <u>e</u>	30. Name and address of person who completed cause of death (Ite 31. Date filed (Mooth, Day, Year) 32. Registrar's Sign	parure on	10 27,	SUITE L	1,100.	504	MAD.	21209	
	Regist		MAI U O ZUUT JARAGAA	100							

Division or Vital Records, P.O. Box 68760 To the Hospital or Attending | within 24 hours after death. To the Funeral Director; After

> 5 State Registrar

completely

Medical

29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) Registrar's Signature MAY 08 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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and manner stated.

368

29c. License number

28365

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** Apri 2346 2007 20 CHRISTINA NICOLE HUNTER /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner POINSULA W100m100 Center SALIS 6419 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 8. Date of Birth (Month, Day, **Funeral** Days 1 □ M 2**X** F 33 10/3/1973 Director 225-04-4029 Virginia Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or Items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director Salisbury MD Wicomico 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 926 Snow Hill Rd., Cottage 800 21804 USA Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or the may injury or other traumatic event, the Medical Examines once. 1 ☐ Yes 2 No If Yes, Give Year or Dates: Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🔼 No Specify: Specify. white δ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disabled none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alvin E. Hunter Joan Turner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Turner Dietrich (mother) 2656 Payne Rd., Pocomoke City, MD 21851 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 IXCremation 3 ☐ Removal from State 4/23/2007 Salisbury Crematory Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility. Holloway Funeral Home, Professional Association 103 Linden AVe., Pocomoke City, MD 21851 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** neumani /Medical to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and the burial-transi-Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1. Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

within 24 hours at To the Funeral L completely

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31. Date filed (Month, Day, Year)

201011 32. Begistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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			for State	State of Maryland / Department of H		iene
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	Director		,	M 2 F Yrs. Months Days	Hours Min. (Month, Day,	9. Birthplace (State or Foreign Country)
	Þ		Usual Residence of Decedent	30	2-6	
	arylar show	-	10a. State 10b. County	10c. City, Town or Location		10d. Inside City Limits
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оľ	Pages nent of I int: if its		1 Surial 2 Cremation 3	Removal from State cemetery, crematory or other place	a) Date	Oc. Location - City or Town, State
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D	al or A after i Dire d in by	Certification;	4 Homicide determined	building, etc. (Specify)	City or Town,	State)
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51	7 241		GREGORIO M. BE	LLOSO, M.D.: 5302 CHINABER	RY DR., SALISB	URY, M.D 21801
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature		
	Registr	ar	APR 2 5 20	UI Blown St. Goods		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) April 20, 2007 **Physician** Dorothea Huber Eva 1805 P ^M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Cecil Calvert Manor Healthcare Rising Sun If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09/14/1918 Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 M 2 X F 222-01-9805 Yrs. Director 88 Delaware Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits r than "naturel", or itams 23a or 28a-f ehow the Madical Examiner nust be notified at Elkton 1 Yes 2 No Cecil MD Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2390 Singerly Road 21921 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Pueno Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after in Department of Health and Mental Hygiana. Importent: if item 27 is marked other than "naturel; or iter any njury or other traumatic event, the Medical Examinanana. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NDT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Grant Jacob Weldin Mary Goodman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Judi Murray / Daughter 2390 Singerly Road, Elkton, MD 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 04/26/2007 Linwood, PA Lawn Croft Crematory 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility
Strano & Feeley Family Funeral Home 635 Churchmans Road, Newark, DE 19702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine signed by the attanding physicien and be deteched for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 2 HO 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Honknown page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed certificate 1 Yes 2 No Yes 2 34 Division of Vital iel or Attending Physician: T s aftar death. si Director: After this certificat ed in by the funeral director, pa 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natoral
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide To the Hospitel or Atte within 24 hours after de To the Funerel Directo completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Day John Franklin Hauser, Jr. April 23 2007 4:30 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Citizens Care & Rehabilitation Center Frederick Frederick 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) 1153tM 2□ F Months Days Hours Min. 71 **Director** 577-46-3755 Dec. 9, 1935 Washington, D.C. Usual Residence of Decedent filed within 72 hours after death with the Maryland show 10a, State 10h County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at Director Montgomery Montgomery Village 1 □Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or ? must be r 19301 Watkins Mill Road 20886 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11 Marital Status "natural", or item edical Examiner r Black, White, etc. 1 X Yes 2 No 1953 If Yes, Give
Year or Dates: 1959 1 Never Married 2 Married 1 ☐ Yes 2XX No Specify White þ Specify: 3 ☐ Widowed 4 ☑ Divorced 1959 Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) the Property Manager Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) s 1 and 2 should be fill Health and Mental H tem 27 is marked oth Be John F. Hauser, Sr. Corrinne Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Shott / God-daughter 19041 Staleybridge Rd., Germantown, MD 20874 item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition April 24. 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or = ৯ Resthaven Crematory Frederick, Maryland 4 Donation 5 Dother (Specify) 2007 21. Signature of Funeral Service Licensee Ræsthaven funeral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 23a. Part . Enter the dise shock, or leart fail un. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Fin disease or condition resulting in death) **Physician** Hypertensive Cardiovascular Disease years /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed burial-tra Due to (or as a consequence of) Physician/Medical IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Dementia 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed COPD 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No page 2 s autopsy performed' 1□ Yes 2 🔀 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 X Natural 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident hours after deatl uneral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a 1 Kertifylng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

To the I within 2

Maryland 21215-0036

Baltimore,

Division or Vital Records, P.O. Box 68760,

State Registrar

Robert L. Kaufman, M.I

30. Name and address of person who completed car

(Check only one)

29b. Signature and title of certification

300 W. 9th Street, Frederick, MD 21701 32. Registrar's Signature

se of death (Item 23a) (Type, Print)

and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D 13971

29c. License number

29d. Date signed (Month, Day, Year)

07-03284 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Robert Hewitt State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Month Day April 30, 2007 Robert B. Hewitt al Examiner 0258 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1012 President Street Annapolis Anne Arundel **Funeral** Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24Hrs. | 8. Date of Birth(MM/DB/YYYY) 9. Birthplace (State or Director Days Hours Foreign Country) NY 132-40-2879 59 1X M 4/22/2007 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show notified at once. MD Anne Arundel Arnold 1 Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 940 Hilltop Rd. 21012 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? 14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Married White, etc. White Divorced f Yes, Give Yea 1 Yes 2 X No specify: Specify: δ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Investor Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Blackburn Hewitt Gloria Copp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tina Hewitt Wife 940 Hilltop Rd. Arnold, MD 21012 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 1 XX Burial 2 Cremation 3 Removal from State crematory or other place) Lakemont Cemetery 5/3/2007 Davidsonville, MD Donation 5 Other Specify: 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21041 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart hysician Approximate Interval failure. List only one cause on each line. Between Onset and Medical Death Narcotic and cocaine intoxication Ëxaminer Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical attending physician or use as the burial -X UNPENDED 23a, 27, 28a-f, perME, g867, 5/15/07 TI of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death past 12 months? 2 Month Day Year Pregnant at time of Other (Specify) ned by the atte 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed ficate has been si page 2 should b 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? Yes 2 1 V Yes 2 No 25. Was case referred to medical director, 26.Place of Death (Check only one) Be examiner? Hospital: Other 4 Inpatient 2 After this ER/Outpatient 3 Nursing Home 5 Residence 6 V Other: Scene 2 1 Yes 28a. Date of Injury (Month, Day,Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural Pending Yes 2X No unk Fnd 4/30/2007 2 Investigation Accident unk 28e. Place of Injury At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Suicide 6 X Could not be

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Division filled in by the within 24 hours after or Fo the Funeral Direct

completely Medical

Name and address of person who completed cause of death (Item 23a) Laron Locke MD. AY 0 2 2007

29a. Certifier 1 (Check only one)

Homicide

29b/Signature and title of certifie

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

(Specify)

and manner stated

unk

Registra

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

unk or Town, State)

29d. Date signed (Month, Day, Year)

April 30, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Items 23. Pt I II. 25. 27. 28a-f perME, 2869. 07/12/07dhb

State of Maryland? Department of Health and Mental Hygiene

1- For State Registrar Amend #26 Pt.11 Per Phys Certificate of Death

Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician April 21, 2007 12:00PM Mary Carlyn Hanson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Waldorf Health Care Waldorf Charles | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | November 13,1938 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months 1□M 2XF 214-36-4044 68 Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location r 28a-f show notified at 1 ☐ Yes 2 No Director Accokeek Prince Georges 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number a or 16305 Manning Road 20607 USA "natural", or items 23a dical Examiner must t Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No White Specify: Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Waitress Restaurant es 1 and 2 should be filed vor Health and Mental Hygie I item 27 is marked other I rother traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Carlyn Tyler Neehurst Larry Baine ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Cheryl Hanson/Daughter 16305 Manning Road, Accokeek, MD 20607 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a, Method of Disposition permit. Pages 1
Department of H
Important: If itel
any Injury or otf 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Brinsfield-Echols Crem. 4/25/07 Charlotte Hall,MD 4 ☐ Donation 5 ☐ Other (Specify) M00945 21. Signature of Funeral Service Licensee 22AREHART-ECHOLS FUNERAL HOME, P.A 23a. Part. Enter in disease, or complications that cause the dyath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each ine. 211 St. Mary's Ave. La Plata,MD 20646 Immediate Cause (Final disease or condition resulting in death) Preumonia **Physician** /Medical Due to (or as a consequence of) Dementia Examiner Sequentially list conditions, if any cause in the cause of cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) CERTIFICATION APPROVED BY MEDICAL EXAMINER Examiner death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Vital Records, þ de ression IPS-Chosis 1 Yes 2 No 3 Probably 4 Nnknown Be Completed Pelvic Fracture 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1∐ Yes 2 No Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To Division or this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending 1 Netural 2 Accident 5 Pending investigation 09/2006 Unknown M 1□Yes 2X No Subject fell after death Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of Rural Route Number, City or Town, State) 16305 Manning Rd. Accokeek, MD n 24 hours after de le **Funeral Direct**e lletely filled in by t 4 ☐ Homicide Accokeek, 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Sindlevar APril 23rd, 2007 DOO 61616 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ravi Sindhwani, M.D. 11350 Pembrooke Square, Suite 304, Waldorf, MD 20602 31. Date filed (Month, Day, Year) 32. Resistrar's Signature State APR 2 5 200 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 29date of Maryland Department of Health and Mental Hygiene 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month 0209 Shirley Jean Howard 04 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner REGIONAL MEDICAL Hicomica Center Sallsburg Peninsula If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex **Funeral** 1 □ M 2 🛣 F Director 236-56-8124 68 7/5/1938 West Virginia Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 □ No must be notified Director Maryland Wicomico Willards death with the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 0 7403 Main St. 21874 IISA items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ont I le marked other than "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: white þ 3 Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Ford Motor Credit Collections Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clad Carlin Jr. Dora (unknown) ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 g Department of Health ar Important: If Item 27 Is any injury or other trau once. 7403 Main St., Willards, MD 21874 Garfield Howard, III/son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 4/25/07 Salisbury, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 atterosderotic cardio vascylar Immediate Cause (Final MISEASE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 2 No 1∐ Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 ☑ Natural 5 Pending investigation Injury within 24 hours after death.

To the Funeral Director: After the funeral by the f 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29el. Date signed (Month Day 24,24,2007 29b. Signature and title of certif 29c. License number HOOS 9368 30. Name of address of person who completed cause of death (Item 23a) (Type, Print) Salishury MD 2180 4 Visieli ð CANVIL E. 00 Year) 32. Resistrar's Signature 31. Date filed (Month State 2 5 2007 Registrar

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Vear Month **Physician** RICHARD HUTCHISON 10:55 ₽^M April 27, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1X M 2□ F 02/06/1921 230-14-3750 86 Director Sterling, VA Usual Residence of Decedent death with the Maryland r 28a-f show notified at 10c. City, Town or Location 10a, State 10d. Inside City Limits Director 1 Tyes 2 XNo MD Frederick Middletown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 23a or be 6619 Mt. Church Road 21769 USA the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, or items 11 Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 □ No If Yes, Give Year or Dates: 1944–46 1 ☐ Never Married 2X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White ð 3 ☐ Widowed 4 ☐ Divorced 'natural', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be flied win Department of Health and Mental Hygiens Important; if item 27 is marked other than any injury or other traumatic event, the A once. 12 Machinist U.S. Treasury Dept. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Douglas Luther Hutchison Mary Anderson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Hilda Hutchison - Wife 6619 Mt. Church Road Middletown, MD 21769 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 05/03/2007 Quantico National Triangle, VA 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 721 Elden Street Adams-Green Funeral Home Herndon, VA 20170 recomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part1. Enter the disease, or conshock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 30 minutes cute /Medical Due to (or as a consequence of): Examiner ORUNAL if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical as IF FEMALE: nse If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) P.0. ed by the a detached f 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has page 2 autopsy performed? Yes 2 No certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 ☐ Yes 2 No 1 Inpatient 2 R/Outpatient 3□ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Certification: 1 Natural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Hospital or Attending To the Hospital or Attendl within 24 hours after death.

To the Funeral Director; A completely filled in by the fu

State Registrar

Medical

29a. Certifier

(Check only one)

Kinl and 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

MA 610 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

22037

29d. Date signed (Month, Day, Year)

Brunswick Mp 21716

2007

			For State Registrar	State of M	laryland		artment o			and M		giene Reg. No	107	148	58
	i Table of		1. Decedent's Name (First, Middle, Las	t)							2. Date of De	ath	V	3. Time of D	Death
	Physici /Medic		Constance	Antaki		mphre	У				April	28	Year 2007	9:45P	М
	Examir	er	4a. Facility Name (If not institution, give)		4b. City, Tov	vn, or L	ocation o	of Death			nty of Death		
	markette, k. americatera		Carroll Hospice Do 5. Social Security Number 6. So		ge (In yrs. las	t hirthday)	If Under 1 Y		ninst If Under 2		8. Date of Bir		arroll	-1 (01-1	
Ė.	Funeral Director				85	Yrs.			Hours	Min.	Apr. 4	, ^{Year)}	Coul	place (State or intry) ecticut	
udalis.	TO		Usual Residence of Decedent									, .,			
	laryla show ed at	'n	10a. State 10b. County		10c. City, 7	own or Lo								10d. Inside City 1 XYes 2	
	the M 28a-f notifie	Director	Maryland Carro	011			Wes		nste	er		10g Citizon	of Minet Cour		
	3a or	٥	41 WTTR Lar	ne.			101. Zip C0	211	6 7			10g. Citizen	U.S.A	-	
	death ms 2 r mus	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S.	13.	Was Decedent If Yes, specity			gin? (Spe	cify Yes or No	- 14, F	Race - Americ	can Indian,	
9	or ite		1 Never Married 2 Married	Armed Forces' 1 ☐ Yes 2X If Yes, Give			ir Yes, specity 1 □ Yes 2 X □			i, Puerto i	Rican, etc.)		Black, White,		
8	72 hours after death with the Maryland natural", or items 23a or 28a-f show iteal Examiner must be notified at	d by	3 Widowed 4 Divorced	Year or Dates:								Spe	· Wni		
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P	be file tal Hy d othe	Be	17. Father's Name (First, Middle, Last)	**				18	8. Mother	r's Name	(First, Middle,	Maiden Surr	name)		
yla	ould I Meni narke	P	Hikmet Antaki								red Li				
altimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural;" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (7)	,			ng Address (St							Code)	
ē,	Heall Heall tem 2		David G. Humphrey, 20a. Method of Disposition	nuspand	20b. Plac		TTR Lar sition (Name of matory or other				minste ate		21157 on - City or To	wn State	
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<u> </u>	o a ll o		(atherine	- Horse	er	3	10 Chur	-ch	St.	Ne	w Wind:	sor, M	D 2177	6	
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	/Medical Examiner		resulting in death)	Due to (or as	a consequen	ice of:									
58	8 - #r	ē	Sequentially list conditions, if any, leading to immediate tauts. E. nor Under ying Cause (Disease or injury	b Due to (or as	a consequen	ice of):									
>	outed ansit	Examiner	Cause (Disease or injury that initiated events	C											
0	sate be executed oblysician and the burial-transit	Exa	resulting in death) Last	Due to (or as	a consequen	ce of):									
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Box 6	leath certific attending p	Physician/Mec	IF FEMALE:	23c. If yes, outcome	of pregnancy	,						1			-
ğ	death atter	cian	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 4□Pregnant a	2 Fetal de	ath 3	Ectopic pregn Other (specif						Date of delive Month	ery Day Yea	ar
о. О	at the de by the a tached	hysi	9 Unknown	9□ Unknown				//							
S,	res tha	by P	Part II. Other significant conditions co	ntributing to death b	ut not resultin	g in the ur	nderlying cause	given i	in Part I.		23e. Did to	bacco use co	ontribute to th	ne cause of dea	ath?
ord	w require been sig should b	ted								_	1 D Y	′es 2∏ No	3 □ rob	ably 4 □Unl	known
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<u>a</u>	sician: The law certificate has l irector, page 2 s											med? 2 No	death?	2 N o	
5 :	s certii irecto) Be	25. Was case referred to medical examiner?	Hospital:	ent 2□ER/	Outnotion	4 A - A - D - D - D - D - D - D - D - D -	Othor			(Check only o			HOSPIC	e
ָס _ו	g Physicar this ieral di	n: 70	27. Manner of Death	28a. Date of Inju	ıry 28	b. Time of	1 3 DOA	Injury at Work?	4 L Nurs		e 5 🗆 Resid			Facil	ity
jo :	ending Frath.	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Da	y rear)	Injury			s 2 🗆 N	lo					
Division or	or Att	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of inj building, et	ury - At home c. <i>(Sp</i> ec <i>ify)</i>	, farm, stre	eet, factory, off	ice		28	Bf. Location (S City or Tow	treet and Nur n, State)	mber or Rura	l Route Numbe	er,
ם :			29a, Certifier 1 Certifying Phy	sielen. To the best	of my language	d d a d a d									
	24 ho 24 ho e Fun etely	Medical	29a. Certifier 1 Certifying Phy cone) 1 Medical Exam	iner: On the basis o and manner st	t examination	and/or inv	estigation, in r	ny opini	date and ion, deatl	i piace, a h occurre	nd due to the o d at the time,	ause(s) and date and plac	manner as st e, and due to	ated. the cause(s)	
	vithin To the compl	Me	29b. Signature and title of certifier				29c. Lic	ense nu	umber		1	29d. Date sigi	ned (Month, i	Day, Year)	
) Well	MO				0 5	520	35		Apr	11 30	200	7
-	3		30. Name and address of person who co			a) (Type, I	Print)	nue	د	We	18min	(ta	MO Z	2/157	
	Stat Registra		31. Date filed (Month, Day, Year) MAY 0 8 2007	82. Registr	ar's Signature							·			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Month 2:30 P Huguette Jackson April 20, 2007 /Medical Simone 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's

9. Birthplace (State or Foreign
Country) 1504 Amherst Road Hyattsville der 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days 1 □ M 2 □ F 215-42-8192 71 Yrs. Director July 3, 1935 France Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Maryland Prince George's Hyattsville 10e. Street and Number 10g Citizen of What Country? r than "natural", or Items 23a or the Medical Examiner must be 1504 Amherst Road 20783 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 😿 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No 2 SpecifWhite 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 should be filed whand mand Mental Hygien ris marked other the Executive Secretary Department of Agriculture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked o any Injury or other traumatic Jean Lucien Pechabrier Henriette Marie Jourde 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter 9509 48th Avenue, College Park, MD 20740
Date | 20c. Location - City or Town, State Vivien Patricia MacGregor/ Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition April 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2007 Gate of Heaven Cemetery Silver Spring, Maryland 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Congestive URBUS /Medical Due to (or as a consequence of): Examiner oronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed and burial-tran Due to (or as a consequence of) Box 68760. attending physician Physician/Medical the as use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Por in the past 12 months? 1 ☐ Yes 2 2 No Month Year 4□Pregnant at time of death 5 Other (specify) Yes P.O. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan has autopsy performed? Yes 2000 certificate 1 Yes 2 🗆 No 1 ☐ Yes or Vital 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 2 No Hospital: 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 5 Residence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After i Certification: To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. Linda

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		-	State of Maryland / D	•	artment of He		nd Me		iene eg. No. 🤈 🎧	0.7	11.066
ij	Physici		Decedent's Name (First, Middle, Last)					Date of Dea Month	th Day	Year	3. Time of Death
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A STATE	· LAGIIII		6625 KENT POINT ROAD		STEVENSV	ILLE			QUEEN	ANNE	's
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	th the or 28,	Director	10e. Street and Number		10f. Zip Code			1	0g. Citizen of	What Cour	ntry?
9	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Yes, Give		21666 Was Decedent of His If Yes, specify Cuban 1□Yes 2X No	spanic Origii n, Mexican, I Specify:	n? (Specif Puerto Ric	y Yes or No- can, etc.)	Bla		can Indian, etc.
Maryland 21215-0036	within 72 hours sne. than "natural" ne Medical Ex	Completed b	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give life.	dent's Usual Occupa kind of work done du DO NOT use retired)	urina most c	of working		16b. Kind of B		dustry
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Baltimore, Ma	Pages 1 and 2 nent of Health 8 ant: If item 27 Is ury or other tra	}	20a Method of Disposition 20b. Place of	Dispo	KENT POIN osition (Name of matory or other place		D, ST APRIL		TLLE, 1 20c. Location		
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Ba	permit. Page Department of Important: If any injury or once.		21. Signature of Fangral Service Licensee	1	06 SHAMRO	CK ROA	AD, C	HESTER	, MARYI	NERAI AND	. НОМЕ, Р. <i>А</i> 21619
j.	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	of):	vech	COU	ACEL	espiratory arr	est,		Approximate Interval Between Onset and Death
68760,	icate be executed physician and s the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	of):							
O. Box	The law requires that the death certific thas been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown		□Ectopic pregnancy □ Other (specify)			23d. Date of delivery Month Day Year			
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(IS/		30. Name and address of person who completed cause of death (Item 23a) (STV aut E. Selo Nicu, WC)	Туре,	Print) 900 B	estyl	we	Rd.	Anna	apo	lis, Ulul
	Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signature	H	hearth .						

			For State	State	of Marylar					and M	ental Hy	giene	9		11061	
			State Registrar 1. Decedent's Name (First, Middle, La	act)		Cel	rtiiica	te of E	Jeath		2. Date of De	Reg. No	201		3. Time of Death	Ĺ
	Physicia	an	JOSEPH JOHN	,	NAPKA						Month APRIL	Da 22		ear		
	/Medic Examin		4a. Facility Name (If not institution, gir				4b. City	, Town, or	Location of		APRIL		. County of	07 Death	8:30 P M	-
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	Funeral			Sex 1 X M 2□F	7. Age (In yrs.		If Und	er 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th y, Year,) 9	Birthpi Coun	lace (State or Foreign	-
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	land t		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							1	0d. Inside City Limits	-
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	or 28a	Director	10e. Street and Number		1		10f. Z	ip Code					tizen of Wha		•	
	off with with with with with with with with		19725 Olney Mil	ll Road						833			Jnited			
	tems term	Funeral	11. Marital Status	Armed F	cedent Ever in U	l.S. 13.1	Was Dec If Yes, sp	edent of His	spanic Ori n, Mexicar	igin? (Spe n, Puerto F	cify Yes or No Rican, etc.))-	14. Race - Black,			
0000	rs afte	by F	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, G Year or I	2 ☑ No live Dates:		1 ☐ Yes	2 No	Specify:				Specify:	W.	hite	
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ana	be fill ad oth even	Be	17. Father's Name (<i>First, Middle, Las</i> Walter Knapka	t)							(First, Middle, Kvetk		n Surname)			
Ĕ	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	၉	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	na Addre:	ss (Street a	and Numbe	er or Rura	I Route Numb	er. City	or Town Str	ate Zin	Code)	_
<u> </u>	nd 2 sulth an allth an 27 is rtrau		Dorothy J. Knar		Lfe		_				Brook		-		20833	
ā,	ages 1 and 2 should bent of Health and Ment t: if item 27 is marked y or other traumatic e		20a. Method of Disposition	¬-		Place of Dispo cemetery, crei	sition (Namatory or	ame of other place	e) :	D	ate	20c. L	ocation - Cit	y or To	wn, State	
altimor	T E E E		1 Ma Burial 2 □ Cremation 3 [4 □ Donation 5 □ Other (<i>Sp</i> ec		n State	te of	-		1	4/27	/07	Si	lver	Spr	ing, Md.	
ă	permit. Departr Importa any inji		21. Signature of Funeral Service Lice	ensee	2 . 1			and Addres			uneral	Hon	ne			
	<u></u>		23a. Part1. Enter the disease, or cor	/\ . / =	2aun						aytons		e, Md	. 20	0882 Approximate	-
			shock, or heart failure. List only	y one cause on	each line.					cardiac o	r respiratory a	irrest,			Interval Between Onset and Death	
ALL CONTRACTOR	Physician /Medical		disease or condition resulting in death)	a	Ischemi		iomy	opath	У					+		-
	Examiner			. Due to	Coronar		rosc	leros	is							
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	ecuter ind transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	,											_
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XOD	nding use a	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, or	utcome pf pregn	ancy	-						23d. Date of	of delive	ery	
ה י	death	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No		birth 2 □ Feta gnant at time of o		⊒Ectopic ∃Other (pregnancy specify)					Month		Day Year	
Σ	w requires that the death certific been signed by the attending I should be detached for use as	Physician/Me	9 ☐ Unknown								T				4.1.110	_
Š,	res th	ρ	Part II. Other significant conditions	contributing to	death but not res	suiting in the u	nderlying	cause give	en in Part I				use contribt 2 □ No 3		e cause of death?	
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			25. Was case referred to medical	T				-	26 Place	of Death	1 Yes (Check only o	2 🔼 N	0 1	Yes	2 No	-
-	Physician: rthis certific ral director,	To Be	examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1] Inpatient 2] ER/Outpatier	nt 3 🗆 🛭	Othe					6 ⊠ Other	(Specify) Hospice	-
_	ng fee		27. Manner of Death 1 Natural 5 Pending	28a. Date (Mo	e of Injury nth, Day Year)	28b. Time o Injury	f	28c. Injury Work			8d. Describe					
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UIVISION	or At after d Direct in by	Certification:	4 ☐ Homicide determined	4 28e. Plac	e of injury - At h ding, etc. (Speci	ify)	eet, tacto	лу, опісе		2	City or To	Street a wn, Stat	nd Number (e)	or Rura	I Route Number,	
_	spital ours a neral filled		29a. Certifier 1 Certifying P	hysician: To th	ne best of my kn	owledge, deat	h occurre	d at the tin	ne, date ar	nd place, a	and due to the	cause(s	s) and mann	er as si	tated.	-
	To the Hos within 24 ho To the Fun completely	Medical	(Check only 2 ☐ Medical Exa one)		basis of examination	ation and/or in	vestigati	on, in my o	pinion, dea	ath occurre	ed at the time,	, date ar	nd place, and	d due to	the cause(s)	
	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu	ž	29b. Signature and title of certifier				2	9c. License		2.6			ate signed (/			
	15		Kynikia 7.	nMi	llean	2000		H00.	580	12	14	Щ	brel a	₹ <i>3,</i>	2007	_
	•		30. Name and address of person who					L	,.,,,	Don-I	Do =1		E-M	2.	2055	
	Sta	te	Cynthia M. Will 31. Date filed (Month, Day, Year)	32,	egistrar's Sign				TTTT 1	koaa,	ROCKV	ΤΤΤ€	= MQ.		0855	-
	Registr		APR 2 4 2	007	Page se	H. do	ast's	,								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2007 Irene M Kulcsar April 22 3:29 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 82 1 ☐ M 2 🛣 F 141-12-6265 Jan. 14, 1925 Director New Jersey Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 25 No Directo Maryland Frederick Monrovia 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 11788 Rowe Road 21770 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No if Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Tomchik Anna Mudrik ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Emil A. Kulcsar / Husband 11788 Rowe Rd. Monrovia, MD 21770 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition April 23 Department of I Important: If ite any Injury or ot once. 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Resthaven Crematory 2007 Frederick, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Europal Service Licensee 22. Name and Address of Facility Resthaven Funeral Services, Skkot Cody P.A. Catoctin Mtn. Hwy. Frederick, MD 21701 23a. Part / Enter the disease or complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final) 10 con (Physician disease or condition resulting in death) /Medical Due to (or as a consequer **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1□ Yes 2 1 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Mannet of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation ours after death.

neral Director: Af 2 Accident 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certify 30. Name and address of pe ho completed cause of death (Item 23a) (Type, Print) MD 31. Date filed (Month, Day, istrar's Signature Year) State

Registrar

APR 25

2007

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

APR 24 2007

Registrar's Signature

		For State	State of Ma		/ Depa	artment of H	lealth and N		giene	egible.	11001			
		Registrar 1. Decedent's Name (First, Middle, L	an t)		Cei	rtificate of	Death	2. Date of De	Reg. No.	1001	3. Time of Death			
Physicia	_	Sue Priscilla Le	· .					April	1 ^{Day} ,	2007	5:03 AM			
/Medic Examin		4a. Facility Name (If not institution, gi				4b. City, Town, or	r Location of Death			ounty of Death				
LAGIIIII	C1	Anne Arundel Med		r		Anna	polis		An	ne Arur	ndel			
Funeral Director		219-16-1593	Sex 7. Ag	e (In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, P. Sept. 1	2, 1924	9. Birthp Coun Mary	place (State or Foreign of Land			
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Mary I-f sho fied a	tor	Maryland Anne A	rundel		Anı	napolis					XX Yes 2 □ No			
th the or 28a e noti	Director	10e. Street and Number				10f. Zip Code			_	n of What Coun	-			
ath wi	ral	916 Creek Drive				21403				ed State				
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Properties of Health and Mental Hygiene. In moortant: If them 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married XX Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 XXI If Yes, Give Year or Dates:	Ever in U.S. No	1	Was Decedent of H If Yes, specify Cuba 1 □ Yes ※XXNo	ispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		. Race - Americ Black, White, pecify: Whi	etc.			
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al Hyg	Be C	17. Father's Name (First, Middle, Las	st)	•			18. Mother's Nam			ırname)				
ould b Ment arked atic e	70 T	Albert O. Jones					Sarah Ca							
and 2 sho salth and 1 27 is m er traum		19a. Informant's Name/Relationship Kenneth S. Leito		d		ng Address <i>(Street</i> Creek Dri		apolis,	oer, City or T Mary1	own, State, Zip Land 214	(Code) 403			
ges 1 t of He if iten		20a. Method of Disposition 1 XX Yurial 2 □ Cremation 3	☐Removal from State	cen	netery, cirer	sition (Name of matory or other place		Date		tion - City or To				
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permir Depar Impor any ir		21. Signature of Funeral Service Lic	ensee II			47 Duke o								
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law requires that the death certificate be as been signed by the attending physici 2 should be detached for use as the bu	Physician/Medica	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal d	eath 3	□Ectopic pregnancy □ Other <i>(specify)</i>	/		230	d. Date of delive Month	ery Day Year			
uires that the de signed by the a	þ	Part II. Other significant conditions	Syncyo	ut not resulti	ng in the ui	nderlying cause giv	en in Part I.				ne cause of death?			
ا م شو	Completed	Serzure		-				24a. Was auto perf	psy ormed?/	prior to con death?	psy findings available mpletion of cause of			
	a l	25. Was case referred to medical					26. Place of Dea	1 Yes	2 No	1 □ Yes	2□No			
ysici iis cer direc	OB	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatie	ent 2 DEF	R/Outpatien	it 3□ DOA Oth	or			☐Other (Specif	(y)			
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ne Hospitt 1 24 hours ne Funera	Medical C		Physician: To the best aminer: On the basis o and manner sta	f examination										
To th Within	Me	29b. Signature and title of certifier	a Rone	ro	M1	29c. Licens	e number 052022	2	29d. Date s	signed (Month,	Day, Year) 7			
3		30. Name and address of person wh MARIA ROME	o completed cause of d	leath (Item 2	3a) (Type,	Print) Lense It	chway 9	Soute 21	00 A	nnapsi	2140)			
Sta Registr		31. Date filed (Month, Day, Year) APR 2 3	2007 32. Registr	ar's Signatur	<i>J</i> .	South	0' /							
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			1 - State State O'		artment of Health and Mertificate of Death	lental Hygien	2007 14000
			Decedent's Name (First, Middle, Last)			2. Date of Death	3. Time of Death
	Physici	an	BRONWYN MARIE !	EGACY		Month 22	2007 0540 A M
	/Medio		4a. Fecility Name (If not institution, give street and nur.		4b. City, Town, or Location of Death		tc. County of Death
н	Examir	er	JOHN MANTIOCKE DO	,	NANTICOKE		Wicomico
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday	If Under 1 Year If Under 24 Hrs.	8. Date of Birth Month, Day, Yea	9. Birthplece (State or Foreign Country)
	Funeral Director		213-78-RUCG 10M 2XF	45 Yrs.	Months Days Hours Min.	2-20-19G	Country)
			Usual Residence of Decedent			VI VD 1	
	ylan		10a. State 10b. County	10c. City, Town or L	ocation		10d. Inside City Limits
	Ma-f	Director	MD WICOMICO	ITMAM	coke		1 □ Yes 2 No
	h the	ire	10e. Street and Number		10f. Zip Code	10g. C	Citizen of What Country?
	th wil	al	2011 MANTICOKE GOA	D	21840	(USA
	dea	Funeral			Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
9	or it	II.	11. Marital Status 1 Never Married 2 Married 1 Yes, Giv	2 X No	1 ☐ Yes 2 No Specify:		Specifys
21215-0036	tiled within 72 hours after death with the Maryland Hygiene. uther then "naturel", or Items 23a or 28a-f show with the Medical Examinar must be notified at	d by	3 Widowed 4 Divorced Year or Di	ites:		1	WHITE
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2	hen hen	g E	Elementary/Secondary (0-12) College (1	-4or 5+)	DO NOT use retired) PERVISOR	MA	HURACTURING
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	ges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene. If item 27 is marked other then "naturel", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		BRIAN FGACY HUSBA 20a. Method of Disposition	20b. Place of Disp		ATTECKE IN	Location - City or Town, State
ō	Pages nent of H int: If ite		1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from	State cemetery, cre	amatory or other place)		
ţ	t. Partimer		* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	SAUSBURY	CREMIATORY 4-95-1		LISBURY, MD A1801
Baltimore,	permit. Pages Department of Importent: If if any injury or o		21. Signature of Funeral Service Licensee	116	2. Name and Address of Facility MESICK FUNERAL HOM?	EPO BOX 61	RINAME UD 81814
			23a. Pert 1. Enter the disease, or complications that c shock, or heart failure. List only one cause on e	eused the death. Do not en ach line.	nter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
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Division	or A after Direction by	rtif	determined 200.1 1400	ng, etc. (Specily)	noot, factory, office	City or Town, Sta	
_	pital Durs Peral filled	0	29a. Certifier 1 ☐ Certifying Physicien: To the	best of my knowledge, dea	th occurred at the time, date and place,	and due to the cause	(s) and manner as stated.
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical Certification:	(Check only 2 Medicel Examiner: On the b	asis of examination and/or in ner stated.	nvestigation, in my opinion, death occurr	ed at the time, date a	ind place, and due to the cause(s)
	o the	Me	29b. Signature and title of certifier		29c. License number	29d. C	Date signed (Month, Day, Year)
	L S L S		Paul R Muss		024812	4	-125/07
	20/20		30. Name and address of person who completed caus	e of death (Item 23a) (Type		y Flurey	1001-1
	100		30. Name and address of person who completed causes 505 Term 57	Poco	moke City M.	0 1 2	-1851
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene -Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Day **Physician** Year Pauline $a^{\ M}$ Montgomery 22, 2007 April 3:05 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Collingswood Nursing & Rehab. Rockville Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 🖫 Director 89 May 18, 1917 Wisconsin 325-12-9875 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show a or 28a-f she be notified a 1 ☐Yes 2F No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a the Medical Examiner must b 412 Southwest Drive 20901 USA Funeral hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 Never Married 2 Married ☐Yes 2 No Baltimore, Maryland 21215-0036 Yes, Give 'ear or Dates: 1 ☐ Yes 2 ☑ No Specify: 2 Specify: White 3 ☐ Widowed 4 € Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation. 16b. Kind of Business/Industry within 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Teacher 12 should be filed whand Mental Hygies Is marked other ti Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any Injury or other traumatic ev Raymond Zoerb Julia Albrecht 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) Greg James Blust/ Son 412 Southwest Drive, Silver Spring, MD 20901 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition April 23 20c. Location 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 2007 Alexandria, Virginia 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Advanced Alzheimer's Dementia /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Ener Underlying Cause (Disease or injury Due to (or as a consequence of): certificate be executed Examin that initiated events resulting in death) Last and Due to (or as a consequence of) Physician/Medical the as attending nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy be detached for in the past 12 months? Day Month Vear 4□Pregnant at time of death 5 ☐ Other (specify) I□Yes 2□No the 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Tyes 2 ☐ No 3 Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No 1 Yes Physiclan: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 M Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 2**□x**No ျှ 1 ☐ Yes 1 | Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Division or Vital Records, P.O. Box 68760, or A Hospital within 24 hours a

death.

State Registrar

2

31. Date filed (Month, Day, Year) APR 2.4 2007

determined



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical

4 ☐ Homicide

29b. Signature and title of certifier

29a. Certifier

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D53365

29d. Date signed (Month, Day, Year)

April 23, 2007

			For State	State	of Mai			of Health and	Mental Hy	giene		
			Registrar Registrar			Ce	ertificate	of Death	1	Reg. No. 🤈	107	14867
	Physici	an	Decedent's Name (First, Mide	dle, Last)					2. Date of D	Day	Year	3. Time of Death
	/Medic			omas		urphy			April			12:23 ^{p M}
ŗ	Examin	er	4a. Facility Name (If not instituti	on, give street and	d number)		4b. City, To	wn, or Location of Deat	h	4c. Coun	ty of Death	
	Same and the	- 9	Bowie Health		7.4	// / /- / / / / / / / / / / / / /) If Under 1	Bowie Year If Under 24 Hrs	0.0-1(0)			George's
à.	Funeral		5. Social Security Number	6. Sex 1 ₩ M 2 □		(In yrs. last birthday Yrs.		Days Hours Min.		ay, Year)	9. Birth	place (State or Foreign ntry)
Ь	Director		577-50-3492 Usual Residence of Decedent		7:	3			Oct.	12, 193	3 Wasl	nington, DC
	and and		10a. State 10b. Count	ty		10c. City, Town or I	ocation				·	10d. Inside City Limits
	faryl fshc ed a	ō										1 □Yes 2 □No
	the l	Director	Maryland Ann 10e. Street and Number	e Arunde	1		Davidso 10f. Zip Co			10g. Citizen o	f What Cou	ntry?
	with a or t be			h Di	D 3		10.1.0.					,
	filed within 72 hours after death with the Maryland Hyglene. vither than "natural", or items 23a or 28a-f show ont, the Medical Examiner must be notified at	Funeral	3303 Patuxen		Road Decedent Ev	er in U.S. 13	. Was Deceden	21035	Specify Yes or N		USA ace - Americ	can Indian,
	fter d riter iner	Fun	1 Never Married 2 Ma		d Forces? ′es 2∐ No			nt of Hispanic Origin? (S Cuban, Mexican, Puer	to Rican, etc.)		ack, White,	
21215-0036	al", o	by	3 ☐ Widowed 4 ☐ Divorce	lf Yes Year	es 2∐ No , Give or Dates:	Korean Conflict	1 ☐ Yes 2 🔀	No Specify:		Spec	^{ify:} Whit	e
ŏ	2 hou ature cal E	Completed	15. Decede	ent's Education		16a. Dec	edent's Usual C			16b. Kind of		
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2	d wit gjene grthe the	mo;	12		9+ (+ +++)		tor_of_	Technical	Services	Servi	ap Sta	tion Dealer
	e file al Hy othe vent,	Be	17. Father's Name (First, Middle	e, Last)			202 02	18. Mother's Na	me (First, Middle	e, Maiden Surna	ame)	readin bearer
<u>a</u>	Aenta Aenta rked tic e	TO E	Thomas Aden	Murphy				Elle	n Marie	Briggs		
Maryland	short and N		19a. Informant's Name/Relation	nship (Type. Print)		19b. Mai	ling Address (S	Street and Number or R	ural Route Numi	oer, City or Tow	n, State, Zip	Code)
	s 1 and 2 of Health a item 27 is other trau		Mary L. Murph	y/ Wife		330	3 Patux	ent River	Road, Da	vidson	ville,	MD 21035
Baltimore,	of He		20a. Method of Disposition			20b. Place of Dist		of a		20c. Location		
Ĕ	Pages nent of H ant: If ite		1 ☑Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other		rom State	l		Cemetery	2007	Silver	Sprin	ng,Maryland
ä	# # # · · ·		21. Signature of Funeral Service	e Licensee			22. Name and A	Address of Facility Collin	e Funor:	al Homo	Tna	
m	permi Depar Impor any ir		Agi-	500	plan			versity Bl				ng. MD 20901
r.			23a. Part1. Enter the disease, shock, or hear failure. Li	or complications the	nat caused to	e death. Do not e	nter the mode o	of dying, such as cardia	c or respiratory	arrest,	211	Approximate Interval Between
d	Physician	2 13	Immediate Cause (Final	st only one cause							11	Onset and Death
	/Medical		disease or condition resulting in death)	a. Due		omyoapat consequence of):	ny				-	20 Years
B	Examiner											
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin	Due Due	e to (or as a	consequence of):						
	cuted id ansit	Examiner	Cause (Disease or injury that initiated events	C.								
o,	exec an an rial-tr		resulting in death) Last	Due	e to (or as a	consequence of):						
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S.		led										
Box	The law requires that the death certifi ate has been signed by the attending bage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		, outcome pf		□Ectopic preg	nanov		1	Date of deliv	*
	deal	Sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 <u>□</u> P	regnant at ti		Other (speci			'	vionth	Day Year
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	uires the signed d be de	by F	Part II. Other significant condi	tions contributing	to death but	not resulting in the	underlying caus	se given in Part I.	23e. Did	tobacco use co	ntribute to t	he cause of death?
ğ	n require been sig should t	ba	Renal Insuff	iciency					1 🗆	Yes 2□ No	3 ⅓ Prol	bably 4 □Unknown
ပ္က	aw requisible been 2 should	plet							24a. Was		. Were auto	ppsy findings available
ř	The law cate has	Completed							perf 1∐ Yes	ormed?	death?	mpletion of cause of 2□ No
<u>ra</u>			25. Was case referred to medic	al				26. Place of De	ath (Check only	2∐•No one)	T I I ES	2 140
>		To Be	examiner? 1 ☐ Yes 2 ☐ x No	Hospital:	1 🗌 Inpatient	2 ER/Outpation	ent 3 DOA	Other:	Home 5 ☐ Res		ther (Speci	fv)
Division or Vital Records,	g Physer this eral di		27. Manner of Death	28a. E	ate of Injury	28b. Time		. Injury at		how injury occ		<i>y</i> /
0	nding F th. : After e funer	iţi	1 Natural 5 Pend 2 Accident inves	ling (stigation	Month, Day	Year) Injury	М	Work? 1 ☐ Yes 2 ☐ No				
<u>/IS</u>	l or Attendafter death Director:	fice	3 ☐ Suicide 6 ☐ Coul	mined 200. F	lace of injury	/- At home, farm, s	treet, factory, o	office			nber or Run	al Route Number,
ā	al or s afte l Dir	Certification:	4 ☐ Homicide		uilding, etc.	(apecity)			City or 10	wn, State)		
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	al C	29a. Certifier 1 X Certify	ing Physician: To	o the best of	my knowledge, dea	ath occurred at	the time, date and place	e, and due to the	cause(s) and	manner as s	stated.
	n 24 n 24 ne Fu	edical	(Check only 2 ☐ Medications)	at Examiner: On t	he basis of e manner state	xamination and/or ed.	nvestigation, in	n my opinion, death occ	urred at the time	, date and place	e, and due t	o the cause(s)
	To th Within To th comp	Me	29b. Signature and title of certif	ief /	7		29c. L	icense number		29d. Date sign	ned (Month,	Day, Year)
)	. 1			2/Cill	le-			D29193		April	23,	2007
	8+1		30. Name and address of person	n who completed	cause of dea	ith (Item 23a) (Type	, Print)					
			Stephen Killi					, #201, Edg	gewater,	MD 210	37	
	Sta	te	31. Date filed (Month, Day, Yea	r) 3	32 egistrar	s Signature			·			-
	Registr	ar	APR 2	1 200/	Maria.	, K. A.	1302)					

State of Maryland / Department of Health and Mental Hygiene-= State Registrer Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Apr. **Physician** Helen Gertrude Marley 17, 2007 2:00 p /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Annapolis Nursing & Rehab Center Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. Nov. 8, 19 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗙 F Yrs. Director 214-16-6903 86 MD Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show Its Medical Examinar must be notified at MDQueen Anne's Chester 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1413 Calvert Road 21619 USA 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Yes 2X No f Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☒ No Specify: ٥ 3₺ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 9 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George William Sprinkle Effie Grace Ward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 an Kurt N. Marley/Son 1413 Calvert Road, Chester, MD 21619 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【I Cremation 3 ☐ Removat from State Metro Crematory Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. ritchie Hwy, Severna Park, MD 21146 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death Artenoscherote Cardiovasular Disease Immediate Cause (Final disease or condition resulting in death) **Physician** eans /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the ettending physicien end hed for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy signed by the ette I be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ģ cete hes been sig , page 2 should b 3 Probably 4 Unknown 1 🗌 Yes Completed 065 micome 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Duorda Jes 2 No 1 ☐ Yes 25. Was case reterred to medical examiner? 26. Place of Death (Check only one) Hospitaf: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident of or Attendation of the order 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide To the Hospitei within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 01852 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4203 Queensbury Rd Hyattsalle MD2078, MI 31. Date filed (Month, Day, Year) State 2007 Registrar

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	Physici	an	Decedent's Name (First, Middle, La								2. Date of Dea Month	Day	Ye	ar	3. Time of Death	-
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	Examir	er	812 Upland Drive		1001)			Salisk		Deall			Wicom			
	Funeral Director		5. Social Security Number 6. S 577–24–0794	ex IXM 2□F	7. Age (In yrs. 82	last birthday) Yrs.		er 1 Year	-	24 Hrs. Min.	8. Date of Birth (Month, Day 8/18/.		9.	Birthpla Counti	ace (Stete or Foreign ry) Sylvania	
	pu .		Usual Residence of Decedent 10a. State 10b. County		10c Ci	ty, Town or Lo	nation							10	d Jacida Cita Limita	-
	Aaryla f eho	ō	Maryland Wicomi	co		alisbur								10	d. Inside City Limits 1 ✓ Yes 2 □ No	
	r 28a-	Director	10e. Street and Number				_	ip Code				l 0g. Citiz	en of What	Count	ry?	-
	th witl	aiD	812 Upland Drive	.			2	21801					USA			
ထ္	should be filed within 72 hours after death with the Maryland in Menial Hygiene. The fire 23a or 28a-f ehow marked other than "natural", or lieme 23a or 28a-f ehow imatic event, the Madical Examinar must be notified at	by Funerai	11. Marital Status 1 Never Married 2 Married	12. Was Dece Armed For 1 Tayes If Yes, Give	ces? 2 🗌 No	1	f Yes, sp	edent of Hi ecify Cuba	spanic Ori n, Mexicar Specify:	i, Puerto I	cify Yes or No- Rican, etc.)		4. Race - A Black, W Specify:	Vhite, e	tc.	
Maryland 21215-0036	hours tural'	ed b	3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Ed	Year or Da	ites: Nav	Y 16a. Deced	tant's He	ual Occupa	tion		1		d of Busine			_
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	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)								(First, Middle,		Surname)			
<u>Ş</u>	hould d Men marke maric	ပ	Louis Miller 19a. Informant's Name/Relationship (Time (Drine)		106 146		/Ca			chriebma		T Ct	7- /	0. 4.1	_
<u>R</u>	id 2 sl ith an 27 is r treur		Bonnie Gallagher		r		-				i Route Numbe Sbury, l			e, <i>zip</i> (J00e)	
ē,	f Hea		20a. Method of Disposition		20b. I	Place of Dispo cemetery, crer	sition (N	ame of	Ţ				ation - City	or Tov	vn, State	-
Ē	Page nent c ant: # ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		otate	alisbur	-		1	4/24,	/07	Sal	isbur	y, 1	MD	
Baltimore,	permit. Pages 1 and 2 should b Department of Health and Menta Important: if Item 27 is marked eny injury or other treumatic e <u>pnce</u> :		21. Signature of Funeral Service Licer		_	H	follo	and Address Way E	uner	al Ho	ome Prot Salisbu	fess	ional	Ass	sociation	
e I	Physician /Medical		23. Part. Enter the disease, or com stock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	a	OPD	th. Do not ent	er the mo	ode of dying	g, such as	cardiac o	r respiratory arr	est,			Approximate Interval Between Onset and Death	_
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Vital Hecords,	e law requ has been ya 2 shoul	Completed									24a. Was a	ın			sy findings available pletion of cause of	-
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<u> </u>	Physician: 1 this cartifical ral director, p	Be	25. Was case referred to medical examiner?	Hospital:				Othe			(Check only or					
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Division	ai or Attending s after death. Il Director: After ad in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place buildin	of Injury - At h	ome, farm, str	eet, facto	ry, office		2	28f. Location (S. City or Town		Number or	Rurai	Route Number,	
	To the Hospital or Att within 24 hours after of To the Funeral Direct Completely filled in by	Medical (29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysicien: To the niner: On the ba and mann	sis of examina	owledge, death ation and/or inv	occurre restigation	d at the tim n, in my op	e, date an inion, dea	d place, a th occurre	and due to the cod at the time, d	ause(s) ate and	and manner place, and	r as sta due to t	ted. the cause(s)	
	To the within 2 To the Zomple	Me	29b. Signature and title of certifier					9c. License		-	2	9d. Date	signed (M	onth, D	ey, Year)	1
1	10)		mally no	ul_	i	40		0	320	14		4/	24/07	-		
_ <	Poly		30. Name and address of person who MAMETH MOO		of death (Iter	m 23a) (Type, W/ F/4	Print)	St:	504	13	50/13/	igu.	in in	D	2184.	
1	Sta Registr		31. Date filed (Month, Day, Year) APR 2. 5. 2	100	gistrar's Signa	ature	9					7				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Richard Wayne Norfolk April 23 2007 /Medical 1812 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Memorial Hospital Prince Frederick Calvert 5. Social Security Number 7. Age (In yrs. last birthday) 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ₽ M 2 □ F 44 Director Maryland 218-74-3114 April 21 1963 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show ns 23a or 28a-f show must be notified at Maryland Calvert St. Leanard Director 1 ☐ Yes 2X No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 23a c 3601 Williams Wharf Road 20685 United States Funeral Pages 1 and 2 should be filed within 72 hours after deathment of Health and Mental Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Examiner Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married ò 1 ☐ Yes 2√2 No ģ Specify: white 3 Widowed 4 XDivorced 'natural", Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry r than the Me Elementary/Secondary (0-12) College (1-4or 5+) 10 truck driver construction If item 27 is marked other or other traumatic event, ti 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Franklin Norfolk Stellena Haulsev 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eugene Atkins – exector 6755 Parkers Wharf Rd. St. Leonard MD 20685 20b. Place of Disposition (Name of cemetery, crematory or other placements) 25 2007 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If any Injury or once, Alexandria Virginia Metropolitan Funeral Service 22. Name and Address of Facility Rausch Funeral home 21. Signature of Funeral Service Licensee 4405 Broones Is. rD. Port Republic MD 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** teletiche /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exami Due to (or as a consequence of) physician s the burial Physician/Medical as attending | nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy performed Yes 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA After this 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation (Month, Day Year) 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician: after death Director: filled in by the within 24 hours a

Baltimore, Maryland 21215-0036

the

State Registrar

29a. Certifier (Check only one)

29b. Signature and title of certifier

29c. License number

1 🗜 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D. BOX 370 HUNTING TOWN MD 20639 31. Date filed (Month, Day, Year)

32. Registr APR 25

			for State	State of M	/larylan		artment of F		d Mental Hy				
	95.0		Registrar 1. Decedent's Name (First, Middle, La	ast)		06	Timeate of	Death	2. Date of De	Reg. No.	200	3 1	Time of Death
	Physici		Alejandria	2017		Negr	on		Month April	Day	Yea	r	
	/Medic Examir		4a. Facility Name (If not institution, gi	ve street and number	r)	Negr	4b. City, Town, o	r Location of De			County of De		:00 P M
			0.402 N	•			Silver	Spring	r		Monto		
3/2	Funeral		5. Social Security Number 6.		Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 F		th av Year)	Montge 9. E	Birthplace (Country)	(State or Foreign
П	Director		584-98-3247	1□ M 2🛣 F	86	Yrs.	Worth's Days	Tiours IVI	May 28				Rico
	and w		Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	ncation					10d In	slde City Limits
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	the N	Director	Maryland Monto	jomery		Sil	ver Sprir	ıg		10a Citi:	zen of What		
	with Sa or t be r		8403 Navahoe D) r i r o			101. 2ip 00de	2090:	,	rog. Oiliz	Lett of Willat		
	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	11. Marital Status	12. Was Deceden	nt Ever in U.	.S. 13.	Was Decedent of H)-	14. Race - Ar	USA nerican Inc	dian,
· ^	fter o	匝	1 ☐ Never Married 2 ☐ Married	Armed Forces					(Specify Yes or No uerto Rican, etc.)		Black, W		,
93	urs a al', o Exam	Ş	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:			1 LaxYes 2 □ No	Specify:	Puerto	Rica	≨ pecify:	Whit	:e
0	72 ho natur lical I	Completed	15. Decedent's E (Specify only highest gr	Education		16a. Dece	dent's Usual Occup	ation	warking	16b. Kir	nd of Busines	ss/Industry	
21	thin an "I	lg .	Elementary/Secondary (0-12)	College (1-4or	r 5+)	life.	kind of work done of DO NOT use retired	daning most or v	working				
Maryland 21215-0036	ed wi ygier ner th t, the	ဦ	5				Homemaker				Own	Home	
Ē	be fill d oth	Be	17. Father's Name (First, Middle, Las	t)				18. Mother's N	lame (First, Middle	-	,		
<u>Ş</u>	should and Men s marke umatic	ျ	Antero Negron						Juanita				
Ja.			19a. Informant's Name/Relationship	(Type. Print)		19b. Mailir	ng Address (Street	and Number or	Rural Route Numb	er, City or	Town, State	, Zip Code)
	es 1 and 2 of Health item 27 I	1 1	Maria Duran/Daug	hter	20h F	1311	7 Bluhill	Road,	Silver S	pring	, MD	20906	<u>. </u>
Baltimore,	Pages 'nent of H		20a. Method of Disposition ★★ Burial 2 □ Cremation 3 [☐Removal from State	e		sition (Name of matory or other plac	₁ Δτ	Date Oril 26	20c. Lo	cation - City	or Town, S	tate
Ħ		1 3	4 □ Donation 5 □ Other (Special		Ga		Heaven Ce	emetery	-	Silve	r Spr	ing.	Maryland
ga	permit. Departr Importa any inji		21. Signature of Funeral Service Lice	insee		F	2. Name and Addres	ss of Facility Collin	ns Funera				00000000000000000000000000000000000000
	402 40		SOR Books Saturday disease or one	, Cool		5	00 Univer	sity Bl	Lvd W	Silve	er Spr	ing,	MD 20901
		0 1	23a. Part1. Enter the disease, or con shock, or heart failure. List only	one cause on each	line.	n. Do not em	er trie mode of dyin	g, such as care	nac or respiratory a	rrest,		Inten	val Between et and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Aspira	tion	Pneumo	nia					2 W	leeks
	Examiner			Due to (or a	s a consequ	uence of):							
		-	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Unhydr Due o (or a		uence of):						2 W	leeks
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,	execi n and ial-tra	Exa	resulting in death) Last	c			Failure					1½y	ears
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ģ	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	ledi										1 10	ar
X R O	leath certific attending p I for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom- 1□Live birth			7e-4:-			2	3d. Date of c	elivery	
	deat e atte	icia	in the past 12 months? 1 □ Yes 2 □ No	4 ☐ Pregnant a			Ectopic pregnancy Other (specify) _				Month	Day	Year
J Ö	at the by th tache	hys	9 ☐ Unknown	9∐Unknown									
	w requires that the de been signed by the should be detached	by F	Part II. Other significant conditions	contributing to death	but not resu	ulting in the u	nderlying cause give	en in Part I.	23e. Did t	obacco us	se contribute	to the cau	se of death?
ב	equir en si ould		Osteoporosis, 0	rthostati	c Hypo	otensi	on 		_ 10	Yes 2	No 3□	Probably	4 □Unknown
Records,	~ Ω 70	Completed							24a. Was		24b. Were	autopsy fin	ndings available on of cause of
	The atte h	E O								ormed?	death	?	
VITall	ician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?						Death Check only	one			
_	hys ldii	2	1 ☐ Yes 2 ☑ No			ER/Outpatier	t 3□ DOA Othe	er: 4 🗆 Nursing	Home 5 🔀 Resi	dence 6	□Other (Sp	ecify)	
	ng P		27. Manner of Death 1 ★Natural 5 ☐ Pending	28a. Date of Inj (Month, D	jury lay Year)	28b. Time of Injury	f 28c. Injun Work	√ at	28d. Describe				
<u> </u>	tendi eath. tor: A	cati	2 Accident Investigation 3 Suicide 6 Could not be	20				Yes 2 □ No					
UIVISION	or At fter d direct n by	Certification:	4 Homicide determined	Zoe. Place of it	njury - At ho etc. <i>(Specif</i>)	ome, farm, str y)	eet, factory, office		28f. Location (a City or Tou		Number or	Rural Rout	e Number,
_	urs a		CO. Carifford 150 Cariffolian B	bushing Talks has	A = 5 }				7/				
	Hos 24 ho Fun etely f	edical	29a. Certifier 1 (Check only 2 Medical Exa one)	hysician: To the bes	of examina	wiedge, deati tion and/or in	n occurred at the tin vestigation, in my o	ne, date and pla pinion, death o	ace, and due to the ccurred at the time,	date and	and manner place, and d	as stated. ue to the c	ause(s)
	To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral Director.	Med	29b. Signature and title of certifier	and manner s	naiou.		29c. License	e number		29d. Date	signed (Mo.	nth. Day V	(ear)
	⊢≯⊢ŏ		> Imfaler	- Kamana	, HI)		D25467			April	-	
,	7		30. Name and address of person who		/ -		Print)						
			T.M. Parler-K					ue, #41	.5, Silve	r Spr	ing, I	MD 20	910
	Sta	te	31. Date filed (Month, Day, Year)	32 Regist	trar's Signa		OF -			1	٠, ٠		
	Registr	ar	APR 2 4 20	NI POR	e B	7.	HOE!						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month JOHN NIMMO /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death KEGIONAL MEDICAL ENTER DALISBURY WICOMICO If Under 1 Year | If Under 24 Hrs. 6 Sev 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Months 1 X M 2 □ F Hours Director 66 214-82-9718 April 26, 1940 New Jersey Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10c. City, Town or Location 10b. County an "natural", or items 23a or 28a-f show Medical Examiner must be notified at Directo Maryland Somerset Westover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8430 Green Hill Lane 21871 Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🖔 No Specify. ò 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) h and Mental Hygie None permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 Is marked other any Injury or other traumatic event; 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arnold Lockwood Helen Nimmo ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roland Adkins (Friend) 5574 Tulls Corner Road - P.O. Box 18 - Marion, MD218 8 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ↑ Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) St. Paul's Cemetery Apr. 26, 2007 Marion, Maryland 21. Signature of Funeral S-rvice Usens 22. Name and Address of Facility Bradshaw & Sons Funeral Home Mary Beth Bradshaw-Pr 306 W. Main St - Crisfield, Maryland 21817 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ACUTE MYOCARDIAL INFARCTION /Medical Due to (or as a consequence of): Examiner SEVERE TRIPLE VESSEL CORONARY ARTERY DISEASE the Hospital or Attending Physician: The law requires that the death certificate be executed SEVERE LEFT VENTRICULAR DYSFUNCTION

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Physician/Medical

IF FEMALE:

23b. Was decedent pregnant

9 Unknown

31. Date filed (Month, Day,

in the past 12 months? 1 ☐ Yes 2 ☐ No

and

attending physician

After this

24 hours a

To the

þ

Completed

Division or Vital Records, P.O. Box 68760

Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death

3 ☐ Ectopic pregnancy 4□Pregnant at time of death

5 Other (specify)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

9 Unknown

HEART AILURE

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

23d. Date of delivery

07

USA

1135

10d. Inside City Limits

1 ☐ Yes 2 No

Birthplace (State or Foreign Country)

White

Approximate Interval Between Onset and Death

24a. Was an

autopsy performed 2 No Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

Day

Year

o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2 FR/Outpatient 3	Othor	ath Check only one) Home 5 ☐ Residence 6 ☐ Other (Specify)
tification: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occurred
edical Certific	4 Homicide determined	28e. Place of injury - At home, farm, street, the building, etc. (Specify)	actory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
	29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☐ Medical Exam	yslcian: To the best of my knowledge, death occ niner: On the basis of examination and/or investi- and manner stated.	urred at the time, date and plac gation, in my opinion, death occ	e, and due to the cause(s) and manner as stated. urred at the time, date and place, and due to the cause(s)
ž	29h Signature and title of certifier		29c License number	29d Date signed (Month Day Year)

and manner stated. 29b. Signature and title of certifier

Year

29c. License number

29d, Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 614-D ala

Drive

salisbury

State Registrar

2007

			1- For State of Maryland Registrar		artment of rtificate o			giene	7 14873	
	Dhusis		Decedent's Name (First, Middle, Last)				2. Date of Dea Month	ath	3. Time of Death	
	Physici /Medi		William Edward Neilson, Jr.				Apr.	17. 200	1:20 p M	
	Examir	ner	4a. Facility Name (If not institution, give street and number)			, or Location of		4c. County of [
			Anne Arundel Medical Center 5. Social Security Number 6. Sex 7. Age (In yrs. Ia:	ne bisebuda)	If Under 1 Yea	Annapol		Anne Arundel		
	Funeral Director		213-01-2152 1\(\frac{1}{12}\)M 2 \(\Gamma\) 92	Yrs.	Months Day		Min. (Month, Day	r, Year)	Birthplace (State or Foreign Country)	
	v		Usual Residence of Decedent		!		Jul. 2	8, 1914	PA	
	arylar show	_	10a. State 10b. County 10c. City, MD Anne Arundel	Town or Lo		Arnold			10d. Inside City Limits	
	be M	Director	10e. Street and Number						1 ☐ Yes 2√2 No	
	with	ក់	1167 Old County Road		10f. Zip Code	21012		10g. Citizen of Wha		
	death ms 23	era	11. Marital Status 12. Was Decedent Ever in U.S.	. 13.1	2.7		in? (Specify Yes or No-		American Indian,	
39	ould be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "natural", or Itams 23e or 28e-f show afte event. I've Medical Examinar must be requified at	by Funeral	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No 1 Widowed 4 Divorced 1 Yes, Give WWII	i	f Yes, specify Cu 1 ☐ Yes 2 🔀 N		in? (Specify Yes or No- Puerto Rican, etc.)	Black, V Specify:	White, etc. White	
Õ	72 ho	Completed	15. Decedent's Education	16a. Deced	dent's Usual Occ	upation	, , , ,	16b. Kind of Busin	ess/Industry	
2	thin 7	nple	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)		kind of work don DO NOT use reti		1			
7	led willygien har th		12	Carp	enter/Ca	1			inghouse	
Maryland 21215-0036	uld be fil Mental H irked ott	To Be	17. Father's Name (First, Middle, Last) William Neilson				's Name (First, Middle, e Shaffer	Maiden Sumame)		
Mar)	ind 2 sho aith and h 27 is ma ar trauma		19a. Informant's Name/Relationship (Type, Print) Ronald H. Doub/Son	19b. Mailin 5359	g Address (Street) Iron P	et and Number en Plac	or Rural Route Number ce, Columbia	r, City or Town, Star	te, Zip Code) 044	
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itams 23e or 28a-f show any injury or other traumatic evant, the Medical Examiner must be notified at once.		1 Burial 2 Cremation 3 Removal from State	netery, cren	sition (Name of natory or other pi		Apr. 20,	20c. Location - City		
Balti	permit. Departm importal any inju		2) Signature Fruneral Service Licensels	- 32	and Add	ress of Facility	. P.A. Seve	rna Park	Funeral Home	
	-	-	23 and Enjer the disease, or complications that caused the death.	4.	95 GOV.	WICCITE	e mwy, beve	ina Park,	Approximate	
3	Physician		shock, owneart failure. List only one cause on each line.		·		,		Interval Between Onset and Death	
	/Medical	1	mediate ause (Final disease or, ondition resulting death) a	nce of):						
	Examiner		Sequentially list conditions, b. Peritonit	Ś						
	Sit ad	lne	ff any, leading to immediate cause. Enter Underlying Clause, Ublocke or i they	nce of):	1-1-3	> -				
	and and Il-tran	Examine	that initiated events resulting in death) Last C. Due to (or as a consequent	nce of):	blad	iver			1	
8/60	cate be executed physician and the burial-transit	alE		100 01).						
89	ificate g phys	edicai	d					I by you		
XOR	eath certifi attending for use as	M/W	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnance					23d. Date of	delivery	
	the death certifi y the attending p	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Ectopic pregnant Other (specify)	cy		Month	Day Year	
л О	that the de ned by the a detached t	Phy	9 LI OTIKTOWN							
rds,	w requires that been signed b should be deta	þ	Part II. Other significant conditions contributing to death but not resulti	ng in the un	iderlying cause g	iven in Part I.			e to the cause of death? Probably 4 Monknown	
ecord	aw 2 sl	Completed	Acute renal tailure				24a. Was a autops	n 24b. Were	autopsy findings available to completion of cause of	
<u> </u>	That age	Con	myo condict interction	$\overline{}$			perform	ned?// death	res 2□No	
Vital	ysician: This certificate	Be	25. Was despreferred to medical examiner?				f Death (Check only on	e)		
_	Syr Sir	P	1 Yes 2 No No No Inspiral 1 Inpatient 2 □ ER	VOutpatient	3 DOA		ing Home 5 Reside		Specify)	
SION	ding Ph h. After th funeral	tlon	1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	Bb. Time of Injury		ork? ∃Yes 2 □ No		w injury occurred		
S	Attance r death	ertification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home	a, farm, stre			28f. Location (St.	reet and Number or	Rural Route Number.	
2	tai or s afte al Diri	Cert	4 ☐ Homicide building, etc. (Specify)				City or Town	, State)		
		dical	29a. Certifier (Check only one) 1 ✓ Certifying Physician: To the best of my knowle 2 ☐ Medical Examiner: On the basis of examination and manner stated.	dge, death and/or inv	occurred at the t estigation, in my	time, date and popinion, death	place, and due to the ca occurred at the time, da	use(s) and manner ate and place, and c	as stated. due to the cause(s)	
	To the comp	×	29b. Signature and title of certifier		29c. Licen	ise number	25	9d. Date signed (Mo	onth, Day, Year)	
		\triangleleft			Do	05820	17	4/17/0	7	
	1		30. Name and address of person who completed cause of death (item 23		rint)	110	000	1	P. MO	
	1()		31. Date filed (Month, Day, Year) 82. Registrar's Signature		unica	الانان	4 centr	majo	(C) VII)	
	Stat Registra		APR 2 0 2007	KA	Such					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Ragistra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Apr. **Physician** 15, 200^{Year} Madeline M. Overholser 7:25 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 96 Berrywood Drive Severna Park Anne Arundel 8. Date of Birth (Month, Day, Year) Apr. 15, 1929 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min 1 ☐ M 2 🖫 F 78 Yrs. PA 192-22-7852 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or itema 23a or 28a-f show traumatic event, the Modical Examinar over to notified at Anne Arundel 1 ☐ Yes 2 No Completed by Funeral Director Severna Park MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 96 Berrywood Drive 21146 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. □Yes 2No 1 Never Married 2 X Married White Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Decupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Folk Artist Painter Art 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be fill and Mental H Be Archibald Paul Wingo Madeline Hood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an John Harold Overholser/Husband 96 Berrywood Drive, Severna Park, MD 21146 other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Apr. 20, 1 Burial 2 □ Cremation 3 □ Removal from State ö permit. Page Department of Important: If any injury or MD Veterans Cemetery Crownsville, MD 4 □ Donation 5 □ Other (Specify) 2007 Barranco & Sons, Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Parv. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** meta etales disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day 4☐ Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown à Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, pe icate has been sig r, page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy performe 20 No director, 25. Was case referred to medical 26. Place of Death | Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5. Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Leath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident the Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide within 24 hours after To the Funeral Dire Hospital ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examillier. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 1)53306 , mo 110 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ste 200 fragales 300 15 stgot LI Curfis Marris 31. Date filed (Month, Day, Year) APR 2 0 State Registrar

			1 - For State Registrar	State of M	iai yiai id /	-		te of L		ina ivi	ена пу	/grene Reg. No	2007	14875
	Physici /Medic		1. Decedent's Name (First, Middle, I Anne Potts	Last)							2. Date of Do		2007 Year	3. Time of Death 2:25 A M
	Examir		4a. Facility Name (If not institution, g						Location of		-	40	alvert	h
	Funeral Director				ge (In yrs. last	birthday) Yrs.	If Unde	T 1 Year Days	If Under 2 Hours	24 Hrs	8. Date of Bi (Month, Di Dec 9,	-th	0.00	hplace (State or Foreign unitry) England
ith the Maryland	or 28a-f ahow se notified at	Director	10a. State 10b. County	Calvert	10c. City, T			p Code				10g. Ci	tizen of What Co	10d. Inside City Limits 1 □ Yes 2 菜No untry?
1215-0036 within 72 hours affer death with the Maryland	and Menial Hygiene. Is marked other than "natural", or items 23s or 28s-f show eumatic event, the Medical Examinat must be notified at	by Funeral	8821 Harmony Co	12. Was Deceden Armed Forces 1 □ Yes 2 ☒ If Yes, Give Year or Dates	:?] No :		1 🗆 Yes	edent of Hi ecify Cubai	Specify:		cify Yes or N Rican, etc.)		U.S.A. 14. Race - Ame Black, White Specify: Will Kind of Business/	e, etc. nite
Baltimore, Maryland 21215-0036 Jermit. Pages 1 and 2 should be filed within 72 hours af	Hygiene. ther then "ne nt, the Media	Completed	(Specify only highest of Specify only highest of Specify 12 12 17. Father's Name (First, Middle, La	grade completed) College (1-4or	5+)	(Give life. (Omema	kind of w	ork done d use retired,	uring most		(First, Middle		Own Hor	·
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Kecords, P.O The law requires that the	been signed beshould be defe	by	Part II. Other significant conditions ANEM 17	contributing to death	but not resulting	g in the ur	nderlying	cause give	n in Part I.			tobacco i Yes 2		the cause of death?
	ofe has page 2	Completed											prior to death?	topsy findings available completion of cause of
T OT	ter this neral di	ation; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigati	Hospital: 1 Inpati	ury 28b	Outpatien o. Time of Injury		28c. Injury Work	r: 4X Nur:	sing Hom	Check only one 5 Resi	dence	6 □Other (Spec	cify)
DIVISION tel or Attanding	within 24 hours after death. To tha Funerel Director: Al completely filled in by the fu	Certification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	building, e	tc. (Specify)						City or To	wn, State	ə)	ral Route Number,
the Hospi	hin 24 hou tha Funer npletely fill	Medical	one)	Physician: To the best aminer. On the basis of and manner s	or examination	dge, death and/or inv	estigation	i, in my op	inion, death	place, a n occurre	nd due to the d at the time,	date and	d place, and due	to the cause(s)
) P	C T wit	-	29b. Signature and title of certifier 30. Name and addrage of person wh	M D	Magath (Itam 22)	a) /Timo /		c. License	number	70		/ /	te signed (Month	
9	Sta Registr		Peter Wisniewsk 31. Date filed (Month, Day, Year)	i, MD 110	Hospit	al R		Prin	ce Fr	eder	rick, M	D 2	0678	

Ammended box #5 per F.D. WSH Carroll Co
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Lily May Primus 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Carroll Hospital Center <u>Westminster</u> Carroll 8. Date of Birth (Month, Day, Year) 5. Spejal Segurity Number 216-30-1215 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) Days Hours 1 ☐ M 2 XF 65 12/24/1941 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits 1 ☐Yes 2☐No MD Carroll Hampstead 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1709 Fairmount Road 21074 <u>United States</u> 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2√2 No Specify White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Bridge Company 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Redman Blanch Bosley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank A. Primus 1709 Fairnount Road Hampstead, Maryland 21074 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Dulaney Valley Mem. 4/26/2007 Timonium, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Eline Funeral Home, 934 South M001490 Main Street Hampstead, Maryland 21074 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) OF THE LEFT GEANGRENE Due to (or as a consequence of): Sequentially list conditions, if y leading to in the late cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequenting Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Day Year 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? END-STAGE RENAL DISTASE 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown CARDIOVASCULAR DISEASE ARTERIO SCLEROTIC 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy perform 2X No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury 1 □ Yes 2 □ No.

or Attending Physician: The law requires that the death certificate be executed burial-transit Division or Vital Records, P.O. Box 68760, the has this certificate the Director; filled in by To the Hospital within 24 hours at within 24 hours a completely

Physician

*/Medical

Examiner

Funeral

Director

r 28a-f show notified at

"natural", or items 23a or ? edical Examiner must be r

Medical

the

al Hygiene.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event

Physician

/Medical

Examiner

Examiner

filed within 72 hours after death

Baltimore, Maryland 21215-0036

Director

Funeral

þ

Completed

Be

Physician/Medical IF FEMALE 23b. Was decedent pregnant in the past 12 months? 9 Unknown þ Be Completed 25. Was case referred to medical examiner? 1 ☐ Yes 2 No Certification: To 27. Manner of Death Natural 2 Accident 6 Could not be determined 3☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier (Check only one) Medical

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Light Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D30263

29d. Date signed (Month, Day, Year) 04-23-07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

MEMORIAL AVENUE, WESTMINSTER, MD 21157 200 FRANCIS KHOO

31. Date filed (Month, Day, Year)

APR 2 4 2007

29b. Signature and title of certifier

32. Registrar's Signature

07-02978 Pamela Pitkin

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. For State Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day April 18, 2007 1030 hrs Examine Pamela Pitkin c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Anne Arundel Annapolis 1131 River Bay Road 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** oreign Count Rennsylvania Hours Months Days Sept. 18, 1944 Director 236-74-2000 62 M Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a. State 10b. County 1 Yes 2 No Annapolis or 28a-f show Maryland Anne Arundel Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
unt: If item 27 is marked other than the filed to the standard other than the standard or items 23a or 28a-f sho must be notified at once. Director 10g. Citizen of What Country? 10f Zip Code 10e. Street and Number United States 1131 River Bay Road 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S Funeral 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces Never Married 2 Married 2 XX No Yes White Specify: If Yes. Give Year Yes ZXX No specify: Widowed 4 XXDivorced ۾ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Counselling Psychological Counselor 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary J. Phillips Be Stephen H. Pitkin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Wheeling, WV 26003 1136 Washington Farms Robert Carr / Brother-in-law 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, crematory or other place) tant: If it Burial 2 XXCremation 3 Removal from State Baltimore, Maryland 4/23/2007 Baltimore Crematory Department of Important: Injury or oth Other Specify 22. Name and Address of Facility John M. Taylor Funeral Home. Inc. 21. Signature of Funeral Service Licensee Annapolis, MD 21401 147 Duke of Gloucester St. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval ysician Between Onset and failure. List only one cause on each line. Death bille a Carbon Monoxide Intoxication Immediate Cause (Final disease __kaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last ınd Physician/Medical AMENDED UNPENDED attending physician or use as the burial To the Hospital or Attending Physician: The law requires that the death certificate be 23d. Date of delivery Box 68760. 23c. If yes, outcome of pregnancy IF FEMALE: Year 23b. Was decedent pregnant in the Month Dav 3 Ectopic pregnancy Live birth Fetal death 2 past 12 months Pregnant at time of death Other (Specify) Yes 2 ✓ No 9 Unknown icate has been signed by the att page 2 should be detached for q Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions P.O. 1 Yes 2 V No 3 Probably 4 Unknown ð Completed 24b. Were autopsy findings available Records, 24a, Was an prior to completion of cause of autopsy death? certificate has Yes 2 V No Yes 26.Place of Death (Check only one) After this certific funeral director, p 25. Was case referred to medical Division of Vital Be Residence 6 🗸 Other: Scene examiner? Nursing Home 5 Inpatient 2 FR/Outpatient 3 2 No 1 Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) FOUND: 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Subject breathed automobile exhaust Certification: FOUND: 1 Yes 2 ✔ No 1 Natural t 24 hours after death.

Funeral Director: A etely filled in by the fu Pending Apr 18, 2007 1030 hrs 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc or Town, State) 1131 River Bay Rd, Annapolis , MD 3 V Suicide Could not be determined (Specify) Garage Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Will Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical within 2 and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certific April 19, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Patricia Aronica-Pollak MD. strar's Signature 31. Date filed (Month.

ORIGINAL

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician 0728M 07 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Salisburi NICOMICO RENINSULA Regional Medica cente If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** M 2□F Days 8 **Director** MaryLand Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits an "natural", or items 23a or 28a-f show Me Ical Examiner must be notified at 1 Yes 2 No Ma **Funeral Director** 100mico 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 180 USA W. Main Pages 1 and 2 should be filed within 72 hours after death v nent of Health and Mental Hygiene. int: If Item 27 Is marked other than "natural", or Items 23s Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Maryland 21215-0036 Specify: Completed by BLAC 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) SHOWELL Elementary/Secondary (0-12) College (1-4or 5+) POULTRY th. DRIVER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LESSIE BRICKHOUSE SHER PAIMER ဂ္ traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Heatth ar
Important: If Item 27 is
any Injury or other trau
once. Juanita Palmer (daughter 8568 Bi-State Blud. Delmar. ma Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4-30-07 Delaware Crematory of Delmarva Delmar, 21 Signature of Funeral Service Lice 122. Name and Address of Facility
Bennic Smith Funeral Home 917 W. ISABella St. Salisbur e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part1. Enter the diseas shock, or heart failure Immediate Cause (Final disease or condition resulting in death) HYPOXEMIC **Physician** /Medical Due to (or as a consequence of): Examiner LUNG MASS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner NEUMONIA sician and burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1☐Live birth 3 □ Ectopic pregnancy Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by RONIC 2 No 13 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 2 N Division or Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident To the Funeral Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours

State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Vohra

APR 25

of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

1 🖃 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

Salisbury MO 2/80/

29d. Date signed (Month, Day, Year)

			1 - For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of F rtificate of I		Mental Hy	rgiene U ∪ Reg. No.	1	14017
1	Physic	ian	Decedent's Name (First, Middle, Last	,				2. Date of De		Year	3. Time of Death
	/Medi		Joseph Harriso		te			April	25 200	7	12:45p. [™]
	Exami	ner	4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Dea	ath	4c. County	of Death	
			Moran Manor Nu 5. Social Security Number 6. Sr				ernport			Legan	
	Funeral Director		234-60-3432	X M 2□F	e (In yrs. last birthday) 68 Yrs.	Months Days	Hours Mir	n. (Month, Da	r^{th} $7, 1938$	Coun	ace (State or Foreign try) 1ey, WV
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Le	ocation				11	Od. Inside City Limits
	Many f sh	ğ	WV Miner	a 1	Keys	or				''	1 X Yes 2 ☐ No
	r 28a	rec	10e. Street and Number	<u> </u>	Rey	10f. Zip Code			10g. Citizen of W	/hat Coun	trv?
	h witi 23e o	Funeral Director	47 Willow Avenu	e		26726	5			JSA	, .
	dea	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba		Specify Yes or No		- America	
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other then "neturel", or items 23e or 28a-f show or other treumatic event, it is Mudical Fran	by	1 ☐ Never Married 2 【 Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 1 If Yes, Give Year or Dates:	No	ir Yes, specify Cuba 1 □ Yes 2 X No		nto Hican, etc.)	Specify.	k, White, e	itc. Lte
20	72 ho	ted	15. Decedent's Ed	ucation	16a. Dece	dent's Usual Occupa	ation	4.	16b. Kind of Bu		
Maryland 21215-0036	within and the "r	Completed	(Specify only highest graves Elementary/Secondary (0-12)	College (1-4or 5	0+)	kind of work done of DO NOT use retired			-		,
d 2	filed with Hygiene. other ther	ပိ	17. Father's Name (First, Middle, Last)		P	lulticraft			Paper		
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ar)	2 sho and h		19a. Informant's Name/Relationship (7	ype, Print)	19b. Maili	ng Address (Street a					Code)
	1 and 1 Health tem 27	1	Linda L. Pezzani	te/Wife	47	Willow Av	enue	Keyser,	WV 2672	6	
Baltimore,	Pages 1 nent of Hi int: If iter		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		20b. Place of Disponsion Commetery, creating C	natory or other place	Apri 20		20c. Location - 0	-	vn, State
altii	그 문문를	l i	21. Signature of Funeral Service Licens			. Name and Addres	. =	-	Keyser		
ä	Depariment Department		1 Breant	Sull		85 S. Mai	-	Smith Fu t Keyse		me 6726	
68760, 左	Itilicate be executed // Medical Brancian and as the burial-transit as the burial-transit	al Examiner	disease or condition resulting in death) Sequentially list conditions, and the sequential sequence cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as b. Oue to (or se	a consequence of): a consequence of):	1193114		, par 6	0.1308	St Ce	Gons Gea
	at the death certifi by the attending tached for use as	Physician/Medical	in the past 12 months? 1 Yes 2 No 9 Unknown	4□Pregnant at 9□ Unknown	2 Fetal death 3 time of death 5	Ectopic pregnancy Other (specify)			23d. Date Mont		V Day Year
ds, l	uires tha	by	Part II. Other significant conditions co	ntributing to death bu	ut not resulting in the ur	derlying cause give	n in Part I.		obacco use contrit 'es 2 □ No 3	oute to the	Δ.
00	w requir	iete	PNEUMONIA	4				24a. Was			, /-
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<u> </u>	icien; Th certificate ector, pag	Be	25. Was case referred to medical examiner?	Inonital:				ath (Check only o	ne)		
o	Attending Physicien: r death. sctor: After this certifics by the funeral director,	n; To	27. Manner of Death	lospital: 1 Inpatie 28a. Date of Injur (Month, Day		28c. Injury	at Nursing F	dome 5 Resid	ence 6 Other		
<u>0</u>	endir sath. or: Af he fu	atic	1 Natural 5 Pending 2 Accident investigation	(Wilding)	Year) Injury	Work? M 1 □ Y	es 2 🗆 No				
Division	al or Attended after death	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc	ry - At home, farm, stre . (Specify)	et, factory, office		28f. Location (S City or Tow	treet and Number n, State)	or Rural i	Route Number,
	To the Hospitel or Attending Physicien, within 24 hours after death. To the Funerel Director: After this centific completely filled in by the funeral director.	edical C	29a. Certifier (Check only one) Certifying Physical Cartifying Phy	sician: To the best oner: On the basis of and manner state	f my knowledge, death examination and/or inv led.	occurred at the time estigation, in my opi	e, date and place nion, death occu	and due to the curred at the time, c	ause(s) and mani late and place, an	ner as stat d due to t	ed. he cause(s)
	To the To the Comp	Me	29b. Signature and title of certifier			29c. License	number	2	29d. Date signed	Month, Da	ay, Year)
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	6		30. Name and address of person who co Harjit S. Sidhu,		ath (Item 23a) (Type, F 25 Bishop	Print)		erland. M	4D 2150:)	
	Stat Registra		31. Date filed (Month, Day, Year)	2. Registra							

Please Type or Print in Black Indelible Ink., Ensure All Copies Are Legible.

AMEND THE Print of Health and Mental Hygiene
State of Maryland / Department of Health and Mental Hygiene 1 - State Registra AMEND#20bperFH4/24/07, BMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 2:03 Irene Rosin April 21, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Casey House Rockville Montgomery If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 □ M 2 🕱 F Yrs. Director 579-14-2782 85 March 21, 1922 District of Columbia Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits show 10a. State 10b. County notified at 1 □Yes 2XINo Director · 28a-f Maryland Montgomery Rockville 10q. Citizen of What Country? 10e. Street and Number 10f. Zip Code Marinelli Road, permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medikal Examiner must be none. 20852 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 酉 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify ģ 3 ☐ Widowed 4 ☐ Divorced Caucasian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Shop Owner Self-employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ျှ Sam Rosin Esther Goldstein 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Rosin - Cousin 104 Prospect Street, Middletown, MD 21769 20b. Place of Disposition (Name of cemetery, crematory or other place)
SOLOM
Beth Shalom Cemetery Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ■ Burial 2 Cremation 3 Removal from State 4/23/2007 4 ☐ Donation 5 ☐ Other (Specify) Capitol Heights, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Non Small Cell Lung Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the death certificate be executed and burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2 No the 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 2 X No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice IPU 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 👿 Natural 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 🚨 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Silliams DO H005803Z April 21, 2007

State Registrar

DHMH 17 Rev 1/2001

Cynthia M. Williams, D.O., Montgomery Hospice, 6001 Muncaster Mill Road, Rockville, Maryland 20855

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Signature

Value

APR 2.4

2

31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician GLadys Ermine Redding /Medical 21 2007 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Sykesville If Under 1 Year | If Under 24 Hrs. | Hours | Min. Brinton Woods Carroll

9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1□ M 3√XF 90 **Director** 215-09-8151 11/24/1916 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show notified at 10h County 1 ☐ Yes 2 ☐ No Funeral Director MD Carroll Sykesville the 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? must be n 1442 Buckhorn Rd United States items a 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after or ment of Health and Mertal Hygiene.
ant: if item 27 is marked other than "natural", or itee any or other traumatic event, the Medical Examinet any or other traumatic event, the Medical Examinet. 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: White Completed by 3 ₩idowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Secretary Carroll Co Public Sch. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Rice Elsie M. Browning 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any injury or other trau Roberta Long (daughter) 2849 Flagmarsh Rd. Mt. Airy, MD 21771 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) Carroll Crematory 4/23/2007 Winfield, MD 4 □ Donation 22. Name and Address of Facility
Burrier-Queen Funeral Home and Crematory, 21. Signature of Funeral Service License 1212 W. Old Liberty Rd. Winfield, MD 21764 not enter the mode of dying, such as cardiac or respiratory arrest, proximate Interval Betw 23a. Part1. Enter the disease, or complications that caused the death. D shock, or heart failure. List only one cause of each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner Due to (or as a consequence of) law requires that the death certificate be executed the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an cate has bage 2 s autopsy performed 2 **□** No Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 2 No Certification: To 1 Yes 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 atural 1 ☐ Yes 2 ☐ No 2 ☐ Accident after death 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide ō hin 24 hours a Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number title of certifier 29d. Date signed (Month, Day, Year) 29b. Signature and 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TRICK TURNOS WD Suite

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signature

2007

	1 - For State Registrar	State of Mary		artment of I <i>rtificate of</i>			ene g. No.	14882
	1. Decedent's Name (First, Middle, Last)		-			2. Date of Death Month		3. Time of Death
Physician /Medical	MARY JOSI	EPHINE	ROBIN			April	24, 2007	5:15 A
Examiner	4a. Facility Name (If not institution, give st	reet and number)		4b. City, Town,	or Location of Deat	h	4c. County of Death	ı
	3289 Sackertown Ro				risfield	O Date of Blat		rset
Funeral	5. Social Security Number 6. Sex	M 2⊠F 7. Age (II	n yrs. last birthday) Yrs.	Months Days		(Month, Day,	Year) Cou	place (State or Fore intry)
Director	219-34-3943 Usual Residence of Decedent		68 Yrs.			_Lecember 2	0, 1938 Mary	<u>/land</u>
/land	10a. State 10b. County	10	c. City, Town or Lo	ocation				10d. Inside City Lim
Man Man	Maryland Somers	act		Cri	sfield			1 □ Yes 2 🔀
vith the Mar t or 28a-f s be notified Director	10e. Street and Number	200	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	10f. Zip Code	DITCIO	10	g. Citizen of What Cou	intry?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Itama 23e or 28a-f show any injury or other traumatic event, the Mouleul Exercities is used by notified at ance. To Be Completed by Funeral Director	3289 Sackertown Ro	oad			21817		USA	
after death v	11. Marital Status	2. Was Decedent Eve Armed Forces?	r in U.S. 13.	Was Decedent of	Hispanic Origin? (S	Specify Yes or No- to Rican, etc.)	14. Race - Amer Black, White	
or Its	1 Never Married XXMarried	1√XYes 2 □ No If Yes, Give	1957-	1 ☐ Yes 2 X XNo		,	Specify:	White
ural', o		Year or Dates:	1958					
ed within 72 horygiene. Ner than "natural to the Mulical to the Mu	15. Decedent's Educi (Specify only highest grade	ation completed)	(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of wo	rking	6b. Kind of Business/li	naustry
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Mental H Mental H Irked oth Itic even	Milford Thornton				Iantha	a Nelson		
shound M mar mar	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Maili	ng Address (Stree			City or Town, State, Zi	p Code)
nd 2 alth a 27 la r trai	Allan Robin (Husba	ınd)	3289	Sackert	own Road	- Crisfie	eld, MD 218	317
s 1 a f Hei item othe	20a. Method of Disposition		20b. Place of Dispo	osition (Name of matory or other pla	ace)	Date 2	0c. Location - City or T	own, State
Page ent o nt: If ry or	XXBurial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)		ASBURY CE	•		il 26. 200	07 Crisfiel	d. Marul
mit.	21. Signature of Funeral Service License	1 1	The second secon	2. Name and Addr	ess of Facility			id/ Halyi
permil Depar Impor any ir	May 2 Path Brade	CASA O	Down			Funeral	Home ield, Maryl	101C 5ac
	23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the	death. Do not en	ter the mode of dy	ing, such as cardia	c or respiratory arre	st,	Approximate Interval Between
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/Medical	resulting in death)	Due to (or as a co		, respective	(00)	use Eu Kaem		
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The law requires that the death certificate be executed to has been signed by the attending physician and sage 2 should be detached for use as the burial-transit completed by Physician/Medical Examiner	that initiated events c. resulting in death) Last	Due to (or as a co	anaguana afti					
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uires that the death certific signed by the attending to do be detached for use as do by Physician/Mer	IF FEMALE: 23b. Was decedent pregnant 23	c. If yes, outcome of p	pregnancy				23d. Date of deliv	/Arv
atter I for u	in the past 12 months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim		☐Ectopic pregnand ☐ Other (specify) _	у		Month	Day Year
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quire n sig uld b	Right br	two Cancer	·			1 □ Yes	s 2□No 3□Pro	babiy 4 Unkn
The faw requir	_					24a. Was an		opsy findings avai
te ha						autopsy perform	ed? death?	ompletion of cause
certificate has rector, page 2	25. Was case referred to medical				26. Place of De	ath (Check only one		20.00
rhyarcian: this certific ral director, To Be (examiner? 1 ☐ Yes 2 X No	ospital:	2 ER/Outpatie	nt 3 DOA Ot	her: 4 Nursing I	Home 5 Resider	nce 6 Other (Spec	ify)
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tal or Attending P Is after death. al Director: Atter t ed In by the funers Certification;	1 Natural 5 Pending 2 Accident investigation				Yes 2 □ No			
er de recto recto by ti	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury building, etc. (5	- At home, farm, st Specify)	reet, factory, office		28f. Location (Str. City or Town,	eet and Number or Rui State)	ral Route Number,
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0.38 -	(Check only 2 Medical Examination	ar: On the basis of ex:	amination and/or ir	h occurred at the to	ime, date and plac opinion, death occ	e, and due to the ca urred at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
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To the Hospital or Attending Physician: The law with 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 medical Certification; To Be Comp	29b. Signature and title of certifier	Gas an			se number	29		Day, Year)
To the Hos within 24 ho To the Fun completely f	29b. Signature and title of certifier	Gus my		D-	se number -15715	29	April 25,	
	29b. Signature and title of certifier 30. Name and address of person who con			D-Print)	-15715		April 25,	2007
To the Hos within 24 hos to completely 1	29b. Signature and title of certifier		123 Burto	D-Print)	-15715		April 25,	2007

14883 State of Maryland / Department of Health and Mental Hygiene U For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2007 April 23, **Physician** M William Robinson Jr. 8:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1730 Crestwood Circle Salisbury Wicomico 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 8/5/1925 Birthplace (State or Foreign Country)
 New York 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 110 M 2 □ F Yrs. Director 151-22-1535 81 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 'natural', or iteme 23a or 28a-f ahow the Medical Examiner must be notified at 1 XYes 2 No Be Completed by Funeral Director Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1730 Crestwood Circle 21801 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Dyes 2 No If Yes, Give Coast Year or Dates: Cuard 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced Guard 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Quality Control/real estate poultry/real estate of Health and Mental Hygist It item 27 is marked other or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental I William Robinson Sr. Dorothea Jaep 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Robinson/wife 1730 Crestwood Circle, Salisbury, MD 21801 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State permit. Page Department of important: if eny injury or once. Salisbury Crematory 4/25/07 Salisbury, MD 4 □ Donation 5 □ Other (Specify) ature of Funeral Salvice on nace 22. Name and Address of Facility
Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 45CUD /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) attending physicien end for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Dav Year 5 Other (specify) signed by the aid be detached for 4☐ Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an age 2 s autopsy 2 No 1 Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the fun Injury 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Contibing Physician: To the best of my knowledge death occurred at the time, date and place, and due to the nauce(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 23s Cattlion Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 247094 4/24/07 Now 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 54LKBURY 2180 4 VU NATESAN NA 1415 5.31V SNUL 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Amend Item 29d per dr., 2870, 08/01/07dhb

State of Maryland / Department of Health and Mental Hygiene
Per dr., 2870, 08/01/07dhb
Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** April 11:458 23 2007 Flora Dale Rhodes /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Princess Anne Manor Manokin Somerset If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2**[**] F Yrs. Director 240-44-8093 9/12/1933 North Carolina Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-1 show the Madical Examiner must be notified at 1 Yes 2 No Directo Maryland Somerset Princess Anne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 238 10863 S. Jones Creek Circle 21853 USA 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 'natural', or Itame 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white ģ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Itam 27 is marked other then any injury or other treumeth. Elementary/Secondary (0-12) College (1-4or 5+) clerk retail sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be A. Grace Flowers Andrew M. Rhodes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10863 S. Jones Creek Circle, Princess Anne, MD Theresa Lewis/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 4/24/07 Salisbury, MD 21. Signature of Funeral Service Cicensee Polloway Funeral Home Professional Association Could 501 Snow Hill Rd., Salisbury, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MELANUMT /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner physicien and is the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical use as the ettending for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the e 1 ☐ Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 200 No this certificete 1 ☐ Yes 2 ☐ No 1 ☐ Yes 本 29 D Division of Vital To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No I Director: / 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide hours after within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 047094 April 23, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 21804 spece STRISALMY we(1415 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar APR 2 5 2007

		. For	State of Marylan	d / Depa	rtment of I	Health and N	Mental Hy	giene	non 1 or per
		1 - State Registrar		Cen	tificate of	Death		Reg. N62 0 U	1 4885
Physic	ian	Decedent's Name (First, Middle, Last)				Date of De. Month		3. Time of Death
/Medi	cal	Mildred Dolly Ra 4a. Facility Name (If not institution, give			4h City Town	or Location of Death	April	20 , 20 4c. County of	07 5:45 p. M
Exami	ner	Moran Manor Nursir				rnport		Allega	
Funeral		5. Social Security Number 6. Se	x 7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birt (Month, Da	th v. Year)	D. Birthplace (State or Foreign Country)
Director		295-20-3480	М 2⊠F 84	Yrs.	None Bayo	110010			Ohio
iand iand		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Loc	ation				10d. fnside City Limits
Many e-fsh	ctor	MD Allegany	W	esternp	ort				1 ☐ Yes 2X No
death with the Maryland ms 23a or 28e-f show LEINEL by nutified at	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	at Country?
s 23a		25701 Shady Lane	2. S.W.	S 12 VA	215		posty Vos or No	USA 14 Bace	American Indian,
fter de	Funeral	11. Marital Status 1 ☐ Never Married 2☐ Married	Amed Forces? 1 Yes 27 No If Yes, Give			Hispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	Black,	White, etc.
OUGO hours after turel; or its	by	3 Widowed 4 Divorced	If Yes, Give 22 Year or Dates:	1	□Yes 2⁄Q No	Specify:		Specify:	Mite
ING 21213-UU36 be filed within 72 hours after death with the Marylar tal Hygiene. Independent than "natural", or items 23a or 28e-f show event. The Medical Examiner must be nutified at	Completed	15. Decedent's Edu (Specify only highest grad	ication le <i>completed)</i>	(Give k	ent's Usual Occu and of work done O NOT use retire	during most of work	king	16b. Kind of Busi	ness/Industry
within 72 ene. then "nat	dwo	Elementary/Secondary (0-12)	College (1-4or 5+)		e Piano			Private T	'eaching
other	BeC	17. Father's Name (First, Middle, Last)		rrrace	z i idilo	1		Maiden Sumame)	
arylar should be and Menta marked umatic ev	ToB	Ray Dolly				Leah F	1orence	Judy	
0 0 0 0		19a. Informant's Name/Relationship (T		//	1000	t and Number or Rui			
C 75 C4 F		Hubert Raines/ Hus	20b. F	lace of Dispos	ition (Name of		Wester	nport, MI 20c. Location - C	
Fages Transport of tant: If It		1XXBurial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,			atory`or other pla Cemetery		-		
Saltimore, bermit. Pages 1 a Department of Hee mportant: If Item any injury or othe		21. Signature of Funeral Service Licens		22.	Name and Addr	ess of Facility Bas		Riverton, neral Hom	ne
		+ Arian 7	5 8 mith	P	O. Box	215 Fran	klin, W	V 26807	
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	fications that caused the deal ne cause on each line.	h. Do not ente	r the mode of dy	ing, such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death
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/Medical Examiner		1	Due to (or as a consec	uence of):	•				
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6 be executed sician and be burial-transit	al Ex	resulting in death) Last	Due to (or as a consec	uence of):					
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	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown		Ectopic pregnand Other (specify) _	;y 		Monti	n Day Year
T.C.	Phy	9 ☐ Unknown Part II. Other significant conditions co		ulting in the un	doshina onuan a	von in Bart I	220 Did t	obacco use contrib	ute to the cause of death?
Hecords, P.O. The law requires that the tee has been signed by the bage 2 should be detached.	d by	History C	erebro vasalo	V Hec	uding cause gi	Yen in Fait i.		Yes 2 □ No 3	- 6
w requ	Completed	I ha on den	erabro vasalo Fai ; p	Lucal	1. lawil	tions	24a. Was	an 24b. We	ere autopsy findings available
Te The la te has age 2	dmo	99 100	, ,	TYIM	J. W.W.	C1.0-71	autop	osy pri ormed? de	or to completion of cause of ath? Yes 2 No
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DIVISION of a trending after death. Director: An ain by the furnity of the furni	flcat	3 Suicide 6 Could not be	286. Place of Injury - AU	ome, farm, stre					or Rural Route Number,
DIV spitel or A ours after naral Dirso filled in by	Certification:	4 Homicide	building, etc. (Speci	(Y)			City or To	wn, State)	
UVISION To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After compietely filled in by the fune	edical ((Check only 2 Medical Exam	rsician: To the best of my knoiner: On the basis of examina	owledge, death	occurred at the t	ime, date and place opinion, death occu	, and due to the rred at the time.	cause(s) and mani date and place, an	ner as stated. d due to the cause(s)
To the H within 24 To the F complete	Medi	one) 29b. Signature and title of certifier	and manner stated.		1				
¥ ¥ ¥ 8) and			00	12.40		4/27/=	007
		30. Name and address of person who o	ompleted cause of death (Item Mor) 3a Registrar's Sign	n 23a) (Type, F	Print)	-10-7		10	,
_ నీ		Dr. Jesus H.	Tan More	20 M	nor M	ursing H	one l	le Sternp	d+, Md
St Regist	ate	31. Date filed (Month, Day, Year)	32 Registrar's Sign	Thire Con	els.			1	
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J/ ±	72007,		For State Registrar		State	of Maryl	land / [Departm	nent of F cate of a	lealth a	and M	1ental H	ygien Reg. N	eS () ()	7	Photo: street	886
	Physici	an	1. Decedent's Name (First, Middle, Last)									2. Date of D Month April 2		Day Ye	ear	3. Time	
	/Medic	cal -	4. Facility Name //6 and		Eleanor Vi		Smith	4b	City, Town, o	- Location	of Doath	April 2		lc. County of I	Dogth	51	M
	Examir	ner	4a. Facility Name (If not Solomons Num			umber)			olarans	Location	OI Dealli		"	Calvert			
	Funeral Director		5. Social Security Numb 233–03–4058		6. Sex 1 ☐ M 2 🔀 F	7. Age (In 85	yrs. last bir	thday) If L	Inder 1 Year oths Days	If Under Hours	24 Hrs. Min.	8. Date of E (Month, L March	7 192	9. 2 P	Birthpl		or Foreign
	pui ^		Usual Residence of Dec	b. County		100	: City Tow	n or Location					19	12	11	0d. Inside	City Limits
	he Maryla 8a-f shoo otified at	Director	Maryland (alvert	-		, .	sby					10- 6	200		1 □Ye	s 2X No
	with tage or 2		10e. Street and Number 11665 Mesa Th					10	f. Zip Code 20657				10g. C	Citizen of Wha United		-	
40	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status		Armed F	cedent Ever Forces? Marine	in U.S.		Decedent of H specify Cuba			ecify Yes or N Rican, etc.)	No-	14. Race - A Black, N	America White,	an Indian, etc.	
036	ours a	þ	3 Widowed 4 □		If Yes, C Year or	Give Dates:		1□Y	es 2.∏xNo	Specify:	:			Specify: W	hite	<u>}</u>	
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d 2	e filed Il Hygi other rent, t	Be C	17. Father's Name (Firs	t, Middle, L	Last)		1 4.			18. Moth	er's Nam	e (First, Midd	le, Maide				
ylar	Menta	ToE	Harold Davis								yn Ew						
Mar	12 sho		19a. Informant's Name. Manford T. St									al Route Num Land 206		ber, City or Town, State, Zip Code)			
ė,	1 and Health em 2		20a. Method of Disposit		ustaru	2	1		(Name of y or other play	-	_		_	Location - Cit	y or To	wn, State	
altimore, Maryland 21215-0036	Pages ent of nt: If It		1 ☐ Burial 2 ☐ Co	remation		II Glate			y or other play Uneral	- 1		07	Ale	xandria '	Vinc	rinia	
altii	rmit. Partm portar y Inju		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Raisch Funeral Home														
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- 8	Physician /Medical		shock, or heart failure. List only one cause on each line. Interval Betwoonset and D Onset and D											etween			
			disease or condition resulting in death) Due to (or as a consequence of):										Sd	ays			
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Division or Vital Records, P.O. Box 6876	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicia completely filled in by the funeral director, page 2 should be detached for use as the bur	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)							у				23d. Date o Month		ery Day	Year
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ecc	law r	Completed										24a. Wa	topsy	prio	r to cor	psy finding npletion of	s available cause of
a H	r sician: The law s certificate has b lirector, page 2 s				1							1□ Yes			tn? Yes	2 No	
Κİ	s certif	o Be	25. Was case referred examiner? 1 ☐ Yes 2 ☑ No	to medical	Hospital:	Inpatient	2 □ FR/Oι	itnatient 3	DOA Oth		_	h (Check onl)		6 □Other (Cnacifi	(c)	
on or	ding Phys th. : After this funeral di	tion: To	27. Manner of Death	☐Pending investig	28a. Dat	e of Injury onth, Day Yea	28b.	Time of njury	28c. Injui Wor					jury occurred	Speciij	<u>v) </u>	
Divisi	l or Atter after dea Director	Certification:		Could n determi	ned Zoe. Pla	ce of injury - lding, etc. (S		rm, street, f	actory, office			28f. Location City or 7	(Street own, Sta	and Number o	or Rura	l Route Nu	ımber,
_	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Al completely filled in by the fu	Medical C			g Physician: To t Examiner: On the and ma		mination ar										e(s)
	To the within To the comp	Me	29b. Signature and title	of certifier					29c. Licens	e number 133	06		29d. [ate signed (A	Month,	Day, Year)	
	1		30. Name and a dress	of person	who completed ca	use of death	(Item 23a)	(Type, Print)		*				1			
	6		Sylvia Bator					MD 2065	57								
	Sta Regist	ate rar	31. Date filed (Month, L		2 5 2007	Registrar	Signature	H. A	forth	e							

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, or Attending Physician: after death.

| Director: / within 24 hours a

To the Funeral C

completely filled

with the Maryland

Pages 1 and 2 should be filed within 72 hours after death

altimore, Maryland 21215-0036

shock, or heart failure. List only	y one cause on each line.	1		Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Respirator	Pulmonay		Onset and Death
	Due to (or as a consequence of):	0 1	11 -	
22-07-03-17-07-5-12-5-5	Severe	Pulmonaus	Huper	CSIO
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):	7):	
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IF FEMALE:				
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9 Unknown				
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25. Was case referred to medical		26. Place of Death	(Check only one)	
examiner?	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3	DOA Other: 4 Nursing Hom	o EPTDooidonno	6 Dother (Specific)
27. Manner of Death	28a. Date of Injury 28b. Time of	290 Injury et	Bd. Describe how inju	6 Liother (Specify)
Natural 5 Pending	(Month, Day Year) Injury	Work?	od. Describe flow inju	ry occurred
2 Accident investigation	on	M 1 ☐ Yes 2 ☐ No		
3 Suicide 6 □ Could not I		factory, office 28	8f. Location (Street a)	nd Number or Rural Route Number,
4 ☐ Homicide determined	building, etc. (Specify)		City or Town, State	9)
L.				
29a. Certifier 1 Certifying P	hysician: To the best of my knowledge, death oc	curred at the time, date and place, a	nd due to the cause(s) and manner as stated.
(Check only 2 Medical Exa	aminer: On the basis of examination and/or invest and manner stated.	igation, in my opinion, death occurre	ed at the time, date an	d place, and due to the cause(s)
29b. Signature and title of certifier		29c. License number	and Do	te signed (Month, Day, Year)
29b. Signature and title of certifier		250. Elderise Humber	290. Da	te signed (World, Day, Year)
	VV / /	1 03517.3		7-720-0 /
			1	

10 State Registrar

M.D., 110 Hospital Rd., Suite 310, Prince Frederick, MD 20678 Jonathan Lowenthal, 31. Date filed (Month, Day 32. Registi

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Julia Florence Smith /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** If Under 24 Hrs Age (In yrs. last birthday 5. Social Security Number **Funeral** Months Days Hours Min 1 □ M 2 🔀 F 220-24-9276 80 Director May 20, 1926 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Goldsboro Caroline 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15747 Fairhaven Lane 21636 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify Specify: þ 3 XWidowed 4 ☐ Divorced white Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important; if Item 27 Is marked other than " any Injury or other traumatic event, the Magonee. Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bowen George Hamilton Sansbury ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15747 Fairhaven Lane, Goldsboro, MD 21636 Dale E. Smith, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Friendship Cemetery 04-25-2007 Friendship, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 20736 Rausch Funeral Home, P.A., Owings, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 7 houne /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner the burial-transit and Due to (or as a consequence of): attending physician for use as IF FEMALE 23c. If yes, outcome pf pregnancy
1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregpant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9□Unknown signed by ti 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1- u purs 2 No 3 Probably has t page 2 certificate this

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, or Attending Physician; funeral director, After death. the

Baltimore, Maryland 21215-0036

Certification: To Be

		24a. Was an autopsy performed? 1
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: Other:	of Death (Check only one) rsing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)
0 UT 1 D	The book of the bo	delege and disclosure (a) and assess and

To the Hospital

within 24 hours after deal filled in by

> State Registrar

Medical

(Check only one)

31. Date filed (Month, Day,

29b. Signature and title of pertifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5. Washington St. Easton, MS

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

			1 - State of Mary	-	artment of H rtificate of			giene 007	14889
			Decedent's Name (First, Middle, Last)				2. Date of Dea	th	3. Time of Death
	Physici /Medic		Marie S. Sullivar	ì			April 2	21, 2007 Year	10:46 ™
Ì	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	r Location of Dea	th	4c. County of Death	
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	Funeral		1 DM 250 C	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		(, Year) 9. Birthp	place (State or Foreign
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	land ow			. City, Town or Lo	ocation			1	0d. Inside City Limits
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	r 28a	Directo	10e. Street and Number		10f. Zip Code		1	0g. Citizen of What Cour	ntry?
	h with	Die	5618 Spinnaker Drive		2180	1		USA	
	deat	Funeral	11. Marital Status 12. Was Decedent Ever Armed Forces?		Was Decedent of H	lispanic Origin? (Specify Yes or No-	14. Race - Americ	
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ν. Δ	natu	Completed	 Decedent's Education (Specify only highest grade completed) 	(Give	dent's Usual Occup kind of work done	during most of wo	orking	16b. Kind of Business/Inc	dustry
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Maryland 21215-0036	d be	o Be	Edward Soboleski				Dillon	vialour ourname)	
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Ž	s 1 and 2 should I Health and Men Item 27 le marke other traumatic		Bobbi Henderson/daughter	3032	23 Calhou	n Ave.,	Salisbury	y, MD 21804	
စ္	permit. Pages 1 and 2 Depertment of Health a Important: if Item 27 le eny injury or other trau 2005.			b. Place of Dispo	sition (Name of natory or other place	20)	Date	20c. Location - City or To	wn, State
Ë	Pages nent of int: If it iry or o		1 😾 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	gringhi]	11 Memory	4/2	6/07	Hebron, MD	% ∞.
<u>=</u>	permit. Depertm Imports eny Inju		21. Signature of Funeral Service Licensee	Gargens 22	Name and Addre	ss of Facility		fessional As	
m_	89 = 8		Karto R Lewey CFSF	Ē	501 Snow	Hill Rd.	, Salisbu	iry, MD 2180	4
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	/Medical Examiner		resulting in death) Due to for as a con	sequence of):					
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	sit ed	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enner Underlying Cause (Disease or injury	sequence of):					
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28	ficate physics the	edicai	d.						
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ň	death e atte	Cla	in the past 12 months?		Ectopic pregnancy Other (specify)			Month	Day Year
л Э	t the by thatache	Physician/Me	9 ☐ Unknown 9 ☐ Unknown						
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VITAL S	iysician: Th	Be (25. Was case referred to medical examiner?	100		26. Place of De	ath (Check only on		
o	\$ \$	2	1 ☐ Yes 2 ☐ H6 Hospital: 1 ☐ Inpatient	2 ER/Outpatien	t 3 DOA Oth	er: 4 🗆 Nursing I	Home 5 Aeside	ence 6 Other (Specify	<i>'</i>)
	Ing P	on:	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Yea	r) 28b. Time of Injury	Worl	/ at k?	28d. Describe ho	w injury occurred	
DIVISION	Attending ir death. ector: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be			Yes 2 □No			
₹ :	or All	Certification:	4 Homicide determined 28e. Place of Injury - A building, etc. (Sp	At home, farm, str ecify)	eet, factory, office		28f. Location (St. City or Town	reet and Number or Rura n, State)	I Route Number,
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:	withir To th	¥ €	29b. Signature and title of certifier		29c. License	e number	25	9d. Date signed (Month, I	Day, Year)
	80.) I () (Junka -		250	674	(1/24/or	
	18		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)				
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	Star Registra		31. Date filed (Month, Day, Year) 32. Registrar's Si	ignature	B II			۵.	C

State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Reg. No	2007	11.8
e of Death		3. Time of Dear

Physician
/Medical
Examiner

Funeral Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If Item 27 Is marked oth any Injury or other traumatic event

Baltimore, Maryland 21215-0036

Physician /Medical **Examiner**

attending physician and for use as the burial-transit al or Attending Fafter death. Director: To the Hospital or within 24 hours at To the Funeral D

Division or Vital Records, P.O. Box 68760,

Certificate of Death 1. Decedent's Name (First, Middle, Last) Shamburger Jr. D. Berry April 2007 2248 28, 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Clincon

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
(Month, Day, Year)

July 4,1971 Southern Maryland Hospital Prince Georges 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 XM 2 ☐ F Wash., DC 220-11-7976 35 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1X Yes 2 □ No Director Suitland PG Md. 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 2304 Houston Street 20746 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Black Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Driver Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Berry Shamburger Sr. Goldie Henry 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9501 Midland Turn Upper Marlboro, Md. Tamara Washington/sister 20772 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑Burial 2 ☐Cremation 3 ☐Removal from State 4 Donation 5 Other (Specify) Lincoln Cem. 5/4/07 Brentwood, Md. 22. Name and Address of Facility Hodges & Edwards F.H. 21. Signature of Funeral Service Licensee cawar 3910 Silver Hill Rd., Suitland, Md. 20746 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final NEUMONICO la, a m disease or condition resulting in death) Due to (or as a * nsequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Hunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 \sum Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 20 No 1 Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA Certification: To 27. Manne of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) ompleted cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Jose Virgilio Torres-Espinal рМ 21, 2007 2:50 April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Hospice-Casey House
5. Social Security Number | 6. Sex | 7. Age (In yrs. Rockville ear If Under 24 Hrs. Montgomery If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** Months Days Hours 1⊈M 2□F Yrs Director May 25, 1938 Dominican Republic 092-36-6856 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10b. County 10a, State 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a or 20901 Funeral 11215 Oak Leaf Drive, #1202 USA Items 2 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene. is marked other than "natural", or Iter 1 Never Married 2 Married 3 Widowed 4 Divorced 1 ☐ Yes 2 ☐ No If Yes, GiveX X Year or Dates: Baltimore, Maryland 21215-0036 Dominican 1 XYes 2 □ No Specify: Specify White Completed by 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hair Barber 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ramon Antonio Torres Ines Espinal ۵ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20901 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is rr any injury or other traum once. 11215 Oak Leaf Drive, #1202, Silver Spring, MD Luisa M. Torres/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Santiago, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State April 25, Municipal Cemeterio 4 Donation 5 Dother (Specify) Dominican Republic de Santiago and Address of Facility 2007 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 2090 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Septicemia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autonsy performed? 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specity) Hospice 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) April 21, 2007 Dilliam. HOC5803 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6001 Muncaster Mill Road, Rockville, MD 20855 Cynthia Williams, D.O. 31. Date filed (Month, Day, Year) 🕯 egîstrar's Signature State **APR 24** Registrar

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			for State Registrar		C	Certificate of	Death		Reg. No.		
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10	/Medic		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, o	or Location of Death		4c. County	of Death	
	- A	5 5	Shady Grove A	dventist	Hospit	al Ro	ckville		MON	rgom	
	Funeral Director		5. Social Security Number 6. S 579-12-0740	ex 7. Age S≵M 2□F	e (In yrs. last birtho	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Bi	4,1917	9. Birthi Ma	place <i>(State or Foreign</i> ntry) ryland
	Pu ,		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	r Location					10d. Inside City Limits
	aryla shov	5	MD Montgo	morra	roc. Oity, rowin c	Poolesv	illo				Yes 2 □ No
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	with a or	ä	19509 Jerusa	lem Terr	ace		0837		U.S		,
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Õ	72 ho	ted	15. Decedent's Ed (Specify only highest gra	lucation	16a. D	ecedent's Usual Occu	pation during most of wor	kina	16b. Kind of E		•
21215-0036	and 2 should be filed within 7 salth and Mental Hygiene. n 27 is marked other than "I er traumatic event, the Med	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	fe. DO NOT use retire chool Bu	id) ~	_	Monto School		ry Co
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Maryland	2 shot and is m		19a. Informant's Name/Relationship (19b. N	failing Address (Street	and Number or Ru	ıral Route Numi	ber, City or Town	, State, Zi _l	^{p Code)} 20837
	Health tem 27 other tra		Gladys L. Thom 20a. Method of Disposition	as (Wife	·	09 Jerus	arem re.	Date	20c. Location		
Baltimore,	tges it of h if ite or of		1 🔀 urial 2 □ Cremation 3 □		cemetery,	crematory or other pla				•	ille,MD
Ħ	it. Partmer rtant njury		4 □ Donation 5 □ Other (Specifical Service Life of Funeral Service Life of Fu		Jerusa	lem Chur					ME, P.A.
Bal	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other once.		980M2 Kig	trond	enth	246 N. W	ashingt	on St.	Rockvi		MD 20850
Н			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lir	the death. Do no	enter the mode of dy	ing, such as cardiad	or respiratory	arrest,		Approximate Interval Between Onset and Death
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k	Examiner -		Sequentially list conditions,	b. Isch	emic Ca	rdiomyop	athy				months
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P.O.	the d y the tched	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐Unknown							
	The law requires that the death certificate ate has been signed by the attending physpage 2 should be detached for use as the	by Pt	Part II. Other significant conditions of	contributing to death b	ut not resulting in t	ne underlying cause gi	ven in Part I.	23e. Did	tobacco use cor	tribute to	the cause of death?
Ď	w require been sig should b	g pe	1 Yes 2 No 3 F								
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Ä	The I	E						peri	opsy formed? 2 \(\) No	death? 1 ☐ Yes	2 □ No
ital	sician: The law certificate has be irector, page 2 s	Be C	25. Was case referred to medical examiner?				26. Place of Dea				
or V	Physician: r this certifica ral director, p	10 E	1 Yes 2 X No	Hospital: 1X Inpatie	ent 2 ER/Outp	atient 3 DOA		lome 5□Res	sidence 6 🗆 Ot	her (Spec	ify)
n o	ng Pl	Ë	27. Manner of Death 1X Natural 5 □ Pending	28a. Date of Inju (Month, Da		ıry ∣ Wid		28d. Describe	how injury occu	rred	
Sio	tendi eath. tor: A	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be				Yes 2 No		<u> </u>		
Division	or At after d Direct in by	Certification:	4 Homicide determined	building, et	ury - At nome, tarn c. <i>(Specify)</i>	n, street, factory, office			(Street and Num own, State)	per or Hui	ral Route Number,
1	spital ours ours or neral		29a, Certifier 1 X Certifying Ph	nysician: To the best	of my knowledge,	death occurred at the	time, date and place	I e, and due to th	e cause(s) and n	nanner as	stated.
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page.	Medical	(Check only 2 Medical Examone)	miner: On the basis o and manner sta	f examination and/	or investigation, in my	opinion, death occ	urred at the time	e, date and place	, and due	to the cause(s)
	Vithir To th comp	Me	29b. Signature and title of certifier	11/		29c. Licen	se number		29d. Date sign	ed (Month	, Day, Year)
	-		A June 1	II.	MO	D6	4415		4/20/	07	
	8		30. Name and address of person who		eath (Item 23a) (T	ype, Print)					0050
			Nimesh Shah,	M.D. 99	001 Med:	cal Cent	er Dr.,	Rockv	ille,	MD 2	:0850

State Registrar

31. Date filed (Month, Day, Year) **APR 2 4** 2007



State of Maryland / Department of Health and Mental Hygiene U U /

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Physician Temple Ruth 3:30pm 04 /Medical 56 vg. FREUERICK SA 4b. City, Town, or Location of Death 4e Fecility Name (If not institution, give street end number) 4c. County of Death Examiner walkersville, Rederick Co NUWSING 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Dey, Birthplace (State or Foreign
Country) **Funeral** 1 □ M 2 KF 578-24-181 Director Washington, D.C Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours effer death with the Maryland Depertment of Health and Mentel Hygiene. Important: If item 27 is marked other than any injury or other than 1000 permits of the 1000 permits 10a. Stete 10c. City. Town or Location 10b. County 10d. Inside City Limits VA Fairfax Herndon 1 Yes 2 No Be Completed by Funeral Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1310 Yellow Tavern Court 20170 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 (XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced white 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Saxton Jennie V. Mills 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 20170 Gary Temple - Son 1310 Yellow Tavern Court Herndon, VA 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location · City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Adams-Green Funeral Home Herndon, VA 21. Signature of Funeral Service License 22. Name and Address of Facility 721 Elden Street Adams-Green Funeral Home Herndon, VA 20170 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Hours Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest by Physician/Medical Due to (or as a consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 ☐ Yes 2 No 3□ DOA this Director: After this d in by the funerel Dete of injury (Month, Day Year) 27. Manner of Deeth 28d. Describe how injury occurred 1 Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours efter To the Funeral Direc completely filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner es steted.

2 Medical Examiner: In the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. Medical 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D43091 4-26-07 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) Sque TOLL House Ave Zaid, 801 MO 31. Date filed (Month, Day, Year) 32 Registrer's Signature State MAY 0 8 2007

DHMH 16 Rev 6/95

Registrar

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I	hysicia		JAMES	DOOK				Month 04	Da 2.5	y Year 2007	1135 ^M		
- Vales Vales (d. 1	Medic/ Examin		4a. Facility Name (If n	E.	TIMB:	RUUK		4b. City, Town, o	or Location of Death			. County of Dea	
	CXAIIIII	6	MEMORIAL					CIIMBE	ERLAND			ALLEGA	1V
- 01 to - 1	uneral		5. Social Security Nun	mber 6. Se	ex 7. Ag	e (In yrs. last birti			If Under 24 Hrs. Hours Min.	8. Date of B	irth Day, Year)	9. Bir	thplace (State or Foreign
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puq	8		Usual Residence of D 10a. State 1	Decedent 10b. County		10c. City, Town	n or Loca	ntion					10d. Inside City Limits
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affer	or Iter niner		1 ☐ Never Married	d 2□ Married	Armed Forces? 1 ☐ Yes 2 ☑	No				Rican, etc.)		Black, Whit	e, etc.
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and d be file	ever	Be	,						_			i Sumame)	
aryla: should b ind Ment	If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	ဍ	19a. Informant's Nam	Timbrook	ivne Print)	19h	Mailing	Address (Street	Beu t and Number or Ru	.lah Pa		or Town State	Zin Code)
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ESK	72.9		23a. Part1, Enter the	e disease, or comp	olications that caused one cause on each li	the death. Do n				or respiratory	arrest,		Approximate Interval Between
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/M	edical		resulting in death)		Due to (or as	a consequence of	of):	FIUL	OTTIOIOTI				TWEEK.
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	attending physician and for use as the burial-transit						,-						
BOX 68/	phys s the	Physician/Medical			d								
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death G	d for	icia	in the past 12 m 1 ☐ Yes 2 ☐	nonths?	4□Pregnant a	2 ☐ Fetal death t time of death		Ectopic pregnand Other <i>(specify)</i> _	СУ			Month	Day Year
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Or VITAI Physician: T	is certificate has t director, page 2 s	Be (25. Was case referre examiner?	ed to medical					26. Place of Dea	th (Check only	one)		
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ISION ttending death.	tor:	icat	2 ☐ Accident 3 ☐ Suicide	investigation 6 ☐ Could not be		ury - At home, far	ırm stree			28f Location	(Stroot a	nd Number or B	ural Route Number,
LOIVI Lor At after d	Dire d in by	Certification:	4 🗌 Homicide	determined	building, et	c. (Specify)	, 55	,, , ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			own, Stat		arar rioute runnon,
spita	neral / fillec				ysician: To the best								
he Ho	To the Funeral Director: Aft er th completely filled in by the funeral	Medical	(Check only 2 one)	P∐ Medical Exam	niner: On the basis of and manner st		nd/or inve	estigation, in my	opinion, death occu	rred at the tim	e, date ar	id place, and du	e to the cause(s)
To t	To t	Ž	29b. Signature and til	1	\bigcirc			29c. Licens			Λ	ate signed (Mon	
			▶ WW	ham t	am n	M		D 2	25406				26,2007
	4		30. Name and address	ss of person who	completed cause of c	teath (Item 23a) ((Type, Pi	rint)	- A	3ERLAN	n	11) 2.	17/17
10.00		10	31. Date filed (Month	Day, Year)	32. Registr	death (Item 23a) (JE)	ON DRIN	ie wini	SEKLAN	<u>U 11</u>	11) /1	504
4	Sta Registr		M	AY 0 8 21	007 /	as the	600	we!					
			191		0,000	-	4						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician April 21, 2007 Leon Woodard /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 X M 2 □ F Director 432-24-2276 88 May 1, 1918 Arkansas Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show at 1 □Yes 2 KNo Examiner must be notified Director Silver Spring Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number "natural", or items 23a or 20904 U.S.A. 508 Finsbury Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 No WW II 1 Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Engineer 12 should be filed w h and Mental Hygie 7 Is marked other ti 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mamie May Taylor ပ Walter Jefferson Woodard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh
Department of Health and
important: If Item 27 Is m
any injury or other traum 508 Finsbury Road, Silver Spring, Maryland 20904 Johanna R. Woodard - Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/27/2007 Brentwood, Maryland Fort Lincoln Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease of condition resulting in death) **Physician** /Medical Due to (or as a consequence of): APPIRATION PHEUMONIA Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner VACCULAR ACCIDENT CE REVENCE ician and burial-trans been signed by the attending physician should be detached for use as the buria Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ FIBRILLA 1 🗌 Yes 20 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes No 24a. Was an AR EVET To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signa ure and title of certifier 29d. Date signed (Month, Day, Year) D-59284.

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

APR 2 4 2007

PARK/MD-20012

30. Name and address of person who completed cause of death (Item 23a) (Type, PrintShahid Shamin, M.D. WASALVOTON ADVENTIST HOSP. / TAXON A

32 egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day 9 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** or Location of Death 100m100 bur If Under 1 Year | If Under 24 Hrs Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🗓 F Director 218-48-7136 60 2/25/1947 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits Director 1 ☐ Yes 2☐ No Maryland Wicomico Delmar 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 31972 Melson Road 21875 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black. White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. Completed by 3 Widowed 4 Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Poultry Poultry Grower 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Emory Joseph Yoder Viola May Howard ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Suzette w. Beach/daughter 33302 Dagsboro Rd., Parsonsburg, MD 21849 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 4/20/07 Salisbury, MD ature of Funeral Service Licensee 22. Name and Address of Facility
HOLLOWAY Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 homon CFSP 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician 'Medical Due to (or as a consequence of) ≟xaminer Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consectionor off The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. ned by the attending physician detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use, contribute to the cause of death? þ in by the funeral director, page 2 should be 1 ☐ Yes 2/1 No 3 Probably 4 □Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of has autopsy performed death? 1 ☐ Yes certificate 2,2 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient Certification: To 1 🔲 Yes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Matural Injury 1 Tes 2 No 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

To the Hospital or Attending Physiclan: within 24 hours after death.

To the Funeral Director: After this certificat completely filled

> State Registrar

31. Date filed (Month, Day, Year)

2 APR

5

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

32.

Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.--1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year. CAM eps May 0 1 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Midd 0 10 Baltimore 024h onel vee and 8. Date of Birth (Month, Day, Year) Feb. 12, 1940 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months 1**X**M 2□F Hours 67 218-34-0856 Yrs. Director Maryland Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location Show 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 X No MD Baltimore Directo Freeland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21309 Middletown Road 21053 U.S.A. Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Funeral items Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status "natural", or item Black, White, etc. 1 ∏Yes 2 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White ģ Specify: 3 ☐ Widowed 4 X Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Self employed ntal Hygiene. ed other than " event, the Med Elementary/Secondary (0-12) College (1-4or 5+) Blue Chip Machine Co. Tool & Die Maker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be 27 is marked of traumatic even Joseph Donald Webster C. Elaine Myers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health alf item 27 is or other tra Angela Pugliese/Daughter 209 W. Forrest Ave., Shrewsbury, PA 17361 20b. Place of Disposition (Name of cemetery, crematory or other place Moreland Memorial Park Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages
Department of i
Important: If it
any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 2007 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. Q. 1 24 Second St., New Freedom, PA 17349 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 0 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Error Uncertaing Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day Year 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No cate has the autopsy perform 1∐ Yes 2 X No funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 □Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death Certification: 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Mayoz,

Registrar
DHMH 17 Rev 1/2001

13

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

enson

3 Registrar's Signature

3320

2007

MI

Year)

08

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	ate of Maryland		rtment of H			iene eg. No. 200	7 14898
	Physici		Decedent's Name (First, Middle, Last) CAROLYN	R	WIS	E		2. Date of Deat Month MAY	Day Year	3. Time of Death 9:47A M
A Property	/Medic Examin		4a. Facility Name (If not institution, give street FREDERICK MEMORIAL H			4b. City, Town, or FREDERIC			4c. County of De FREDERIC	ath
	Funeral Director		5. Social Security Number 6. Sex 214-16-0724 1	7. Age (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Oct 22,	1923 Ma	irthplace (State or Foreign Country) ry Land
	aryland show dat	<u>_</u>	Usual Residence of Decedent 10a. State Maryland Frederick	10c. City, T	own or Loc			-		10d. Inside City Limits 1 XYes 2 □ No
	ith the Mi or 28a-f	Director	10e. Street and Number		eder 1	10f. Zip Code	700	11	Dg. Citizen of What C	
	be filed within 72 hours after death with the Maryland Ital Hyglene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	A THINIGHTON	/as Decedent Ever in U.S.	13. V	Vas Decedent of Hi Yes, specify Cuba	702 spanic Origin? (S n, Mexican, Puert	pecify Yes or No- o Rican, etc.)	U.S.A. 14. Race - Arr Black, Wh	
5-0036	hours aft atural", or cal Exami	þ	3 Widowed 4 Divorced Y	Yes, Give ear or Dates:	6a. Deced	☐ Yes 2 No	Specify:		Specify: W	
21	d within 72 giene. rr than "na the Media	Be Completed	(Specify only highest grade con	college (1-4or 5+)	(Give l life. D Book	kind of work done of DO NOT use retired Kkeeper	furing most of wor)	rking	Retail Sto	·
Maryland 21	be d o	To Be C	17. Father's Name (<i>First, Middle, Last</i>) Charles Edwar	d Trou	pe		18. Mother's Nan Ada	ne <i>(First, Middle, N</i> Ja		Beard
	s 1 and 2 should if Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type. F Mrs. Gloria Serig, I	onni) Daughter	19b. Mailin 2013	g Address <i>(Street t</i> Monument	Road, M	yersvill	City or Town, State, e, Marylar	Zip Code) nd 2 177 3
altimore,	Φ O + -	ľ	20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ Remov 4 □ Donation 5 □ Other (Specify)	cem	etery, cren	sition (Name of natory or other plac n Mem Gar	dens May		Predericle Frederick	r Town, State k, Maryland
Balt	permit. Pag Department Important: I any injury o		21. Signatur of Funeral Service Licence	euw M00706	10 10	Keeney 6 East C	sgastord hurch St	P.A. Fur Freder	neral Home ick, Maryl	e Land 21701
	Physician	8 9	23a. Parti. Enter the disease, or complication shock, or heart failure. List only one callimmediate Cause (Final disease or condition	ns that caused the death. I use on each line.	_	er the mode of dyin	g, such as cardiad	or respiratory arre	est,	Approximate Interval Between Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as a o insequent		exform	ATION			
8	ecuted nd transit	Examiner	Sequentially list conditions, if any, it are to introduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Dun to (or as a consequen	,					
8760,	icate be executed physician and s the burial-transit	dical Ex	d	Due to (or as a consequen	ce of):					
O. Box 6	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Mec	in the past 12 months?	yes, outcome pf pregnancy □Live birth 2□Fetal de □Pregnant at time of deat □Unknown	eath 3□	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year
rds, P.	iw requires that is been signed by should be detail	by	Part II. Other significant conditions contribu	ting to death but not resultin	g in the un	derlying cause give	en in Part I.		es 2 No 3 I	to the cause of death? Probably 4 Inhown
Vital Records,	The ate h page	Completed						24a. Was an autops perform	y ∠ prior to	
	Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospit	tal: 1 ☐ Inpatient 2 ☐ ER	/Outpatient	: 3 DOA Othe		th <i>(Check only on</i> lome 5 ☐ Reside	e) nce 6 □Other (Sp	ecify)
VISION OF	ing After une	ation: T	27. Manner of Death 28 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	Ba. Date of Injury (Month, Day Year)	b. Time of Injury	28c. Injun Work M 1 🗆			w injury occurred	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
DIVIS	i Diri	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28	e. Place of injury - At home building, etc. (Specify)	, farm, stre	eet, factory, office		28f. Location (St. City or Town	reet and Number or I , State)	Rural Route Number,
	To the Hospital within 24 hours a To the Funeral completely filled	edical	(Check only 2 Medical Examiner:	n: To the best of my knowle On the basis of examination and manner stated.	dge, death and/or inv	estigation, in my o	pinion, death occu	e, and due to the caurred at the time, d	ause(s) and manner a ate and place, and d	as stated. ue to the cause(s)
	With Volume	Z	29b. Signature and Hite of certifier	0		D 4	1951		9d. Date signed (Moi	
	· le		30. Name and address of person who comple	916	la) (Type, F	Chouse	- Ave.	FREDERI	ck. MD	21701.
	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 8 2007	3 Registrar's Signature	Spa	de				

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			For State Registrar	Otate of Marytar		rtificate of			g. No.	14899
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	Cynthia Rose Waug			4h City Town		pril	28, 2007 4c. County of Dear	2020 P M
	Examin	er.	4a. Facility Name (If not institution, give s				or Location of Death		Washingto	
	Funeral		31 West Main Stree 5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	Hancock If Under 1 Year		B. Date of Birth (Month, Day,		hplece (State or Foreign untry)
Mr.	Director		219-26-38/6 CI	M 2X)F	43 Yrs.	Months Days	Hours Min.	eptember	13,1963 W	J
	and		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation				10d. Inside City Limits
	Maryl	tor	MD Washingto	on Ha	ncock					1 X Yes 2 □ No
	or 28a	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	ountry?
	23a c		31 West Main Str			21750			USA	
	er deg	Funeral	11. Wanta Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent of I If Yes, specify Cub	lispanic Origin? (Spec an, Mexican, Puerto Ri	rfy Yes or No- can, etc.)	14. Race - Ame Black, Whit	
336	urs aft	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates:		1□Yes 2∏No	Specify:		Specity:	White
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-1 show ta Medical Exartinar must be rolitied at	Completed	15. Decedent's Educ (Specify only highest grade	cation	(Give	dent's Usual Occup	during most of working	10	6b. Kind of Business	Industry
21	within 72 ho lene. r than "natur I'ra Medical	mple	Etementary/Secondary (0-12)	College (1-4or 5+)	Disab	DO NOT use retire	d)		Marra	
2	77		17. Father's Name (First, Middle, Last)		DISAD	ieu	18. Mother's Name (First, Middle, Ma	None	
lan	ed at b	То Ве	Philip Eugene Waug	⊵h			Erma Rose	tta Bis	hop	
Maryland	de la la		19a. Informant's Name/Relationship (Type		19b. Maili	ng Address (Street	and Number or Rural	Route Number,	City or Town, State, 2	Zip Code)
			Jessie L.Gallion/Gr				Street Har			T Change
lore	S		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ B	emovat from State	cemetery, crei	nsition (Name of matory or other pla	ce)		Oc. Location - City or	
Baltimore,	그는민준		*4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License			Cemetery Name and Addre			<u>rkeley Sp</u> West Main	
Ba	Deparent Dep		TKE W	Marie	G	rove Fune	eral Home,F	.A. Han	cock, MD 2	
H			23a. Part1. Enter the disease, or complishock, or heart faiture. List only or				ng, such as cardiac or	respiratory arres	st,	Approximate Interval Between Onset and Death
	Physician /Medical		trimediate Cause (Finat disease or condition resulting in death)	Cholana		cinoma				
91.0 A	Examiner			Due to (or as a consec	juence of):					
	et	ner	Sequentially list conditions, if any, leading to immediate	Due to (or as a consec	quence of):					
N).	nd nd transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
,09	be executed sicien and burial-transit	al Ex	resulting in death) Last	Due to (or as a consec	quence of):					
687	physi s the t	dice								
.O. Box	The law requires that the death certificate I tte has been signed by the attending physi page 2 should be detached for use as the	Physiclan/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ™ No 9 □ Unknown	3c. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c	al death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of del Month	ivery Day Year
<u>α</u>	es that igned b be deta	by Pt	Part II. Other significant conditions cor	ntributing to death but not res	sulting in the u	nderlying cause gr	ven in Part I.		acco use contribute to	
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Vital		o Be	25. Was case referred to medical examiner?	lospitál: 1 Inpatient 2	ER/Outpatier	nt 3 DOA Ott	26. Place of Death (ce 6 ⊡Other (Spe	C/ft/
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ion	auth. or: After he funera	atlo	1 Natural 5 Pending investigation	(MONIII, Day 10al)	injury		Yes 2□No			
Division	after de Diracte	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, str fy)	reet, factory, office	28	f. Location (Stre City or Town,	eet and Number or Ru State)	ural Route Number,
	To the Hospitel or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral	Medical C	29a. Certifier 1 Certifying Physical Check only 2 Medical Exeminates	sician: To the best of my knoner: On the basis of examina and manner stated.	owledge, deat ation and/or in	h occurred at the ti vestigation, in my	me, date and place, an opinion, death occurred	d due to the cau I at the time, dat	use(s) and manner as e and place, and due	stated. to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier Mottler	talin M.D.		29c. Licens	se number	290	May 1, 200	h, Day, Year)
	3		30. Name and address of person who co	impleted cause of death (Item 130 West His	1 <1	Print) Ha	neock, Mar	y land	21750	
7	Sta Registr	X	31. Date filed (Month, Day, Year) MAY 0 8 2007	32. Registrar's Sign	eture	U	,			
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			1 - State Amend Item	State of Marylar 3 per dr., g8	nd / Depa 5 6,06/ 2	artment of H	lealth and I Death		giene Reg. No. 2 () (07 14900
	Physic /Medi		Decedent's Name (First, Middle, Las MARILYN E	•	ONAVAGE			2. Date of Dea Month MAY		73. Time of Death 5.40 PM M
	Exami		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Locetion of Death		4c. County of	Death
			Washington Adeven			Takoma 1			Montgo	-
de	Funeral Director			7. Age (In yrs.	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Da) NOV • 2	8, 1935	9. Birthplece (State or Foreign Country) PA
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ity, Town or Lo	cation				10d. Inside City Limits
	a-f sh	ctor	MD Prince	George's L	aurel					1 □Yes 2 □ No
	or 28 oe not	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	at Country?
	eath v is 23a must	eral	9238 Cherry Lane,	#26 12. Was Decedent Ever in U	18 13 1	20708		acify Vac or No	U.S.A.	American Indian,
36	n 72 hours after death with the Maryland "natural", or items 23a or 28a-f show adical Examiner must be notified at	by Funeral	11. Maritat Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ X o If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba I□Yes 2 X X o	Specify:	o Rican, etc.)	Black, Specify:	White
Maryland 21215-0036	"naturadical E	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	(Give	lent's Usual Occup	during most of wor	king	16b. Kind of Busin	ness/Industry
121	withir ene. than	ldmo	Elementary/Secondary (0-12) Grade 12	College (1-4or 5+)	1 .	OO NOT use retired • Assista	,		State o	of Maryland
pu	be filed ntal Hygie d other event, It	Be	17. Father's Name (First, Middle, Last)						Maiden Surname)	
Za	es 1 and 2 should be of Health and Mental item 27 is marked o r other traumatic eve	2	Edward St. Ledger		1			th Kenne		
Mar	id 2 sh ith and ?7 is m traum		19a. Informant's Name/Relationship (7 Beth Farley	<i>lype. Print)</i> / daughte:		g Address <i>(Street i</i> 0 Pipes 1			er, City or Town, St e, Maryla	
ľe,	of Hea		20a. Method of Disposition	20b.		sition (Name of natory or other place		Date	20c. Location - Ci	
<u>m</u>	Pages ment of h ant: If ite ury or of		14 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Hemovai from State		Mem. Parl	i i	/2007	Rockvill	e, Maryland
Baltimore,	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licen	/ M007		Name and Address Donaldsor 313 Talbo			P.A. el, Maryl	and 20707
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused the dea one cause on eech line.	th. Do not ent	er the mode of dyin	g, such es cardiac	or respiratory an	rest,	Approximate Interval Between Onset and Death
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8/60,	cate be executed physician and the burial-transit	dical E		d	-	****				
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1	w requires that the de s been signed by the a should be detached f		Part II. Other significant conditions of abdominal aortic	-	-	nderlying cause give	en in Part I.		obacco use contribu	ute to the cause of death?
Records ,	e la has	Completed by						24a. Was a autop perfor	sy prio med? dea	ore autopsy findings available or to completion of cause of ath? Yes 2 🛛 🔏
VITAI	ysician: Th is certificate director, pag	Be C	25. Was case referred to medical examiner?				26. Place of Dea			
0	ys dir	은	1 ☐ Yes 2 ☒ ☒ 0	Hospital: 1XXnpatient 2 28a. Date of Injury	ER/Outpatien		4 Li Nursing H		ence 6 Other	
0	fing After fune	tion	1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	28c. Injun Worl	Yes 2 □ No	zou. Describe n	ow injury occurred	
DIVISION OF	al or Atter after dea Director d in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At h building, etc. (Speci	ome, farm, stre fy)	eet, factory, office		28f. Location (S City or Tow	treet and Number n, State)	or Rural Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier (Check only one)	vsician. To the best of my known in a control of the basis of examination and manner stated.	owledge, death ation and/or inv	occurred at the tin restigation, in my o	ne, date and place pinion, death occu	, and due to the orred at the time, o	cause(s) and mann date and place, and	er as stated. d due to the cause(s)
	To the To the Comp	Me	29b. Signature and title of certifier	- h		29c. License	_	2	29d. Date signed (i	Month, Day, Year)
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	15			yaz Shaw	1, 4	inshing-	ton Ac	l ventis	20th +	ple
	Sta Registi		31. Date filed (Month, Day, Year) MAY 0 9 20	32 degistrar's Sign	di do	whi				1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Day Year nayer 0650 AM Amiel 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Months Hours **№** M 2 F 70 039-32-1822 Sept. 11 1936 Egypt Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√ No Director Prince George's College Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6100 Westchester Park Drive, #1006 20740 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes MNo If Yes, Give Year or Dates: 1XXNever Married 2 ☐ Married 1 ☐ Yes 2 🖾 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) 5+ Teacher P.G. County 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Isaac Amiel Doris Massieh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20740 19a. Informant's Name/Relationship (Type. Print) Kidd/Friend Bonnie Westchester Park Drive, College Park, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State May 11, 2007 Laurel, MD 4 □ Donation 5 □ Other (Specify) MD National Mem. Pk 22. Name and Address of Facility Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licensee M00770 313 Talbott Avenue, Laurel, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Carcinoma of the Pancreas Due to (or as a consequence of): Obstructive Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Cardiac ARRYTHMIR Due to (or as a consequence of): Sa IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy perform 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 1 ☐ Yes 21 No Certifica ation (Street and Number or Rural Route Number,

Physician /Medical Examiner The law requires that the death certificate be executed

Funeral

Director

items 23a or 28a-f show ner must be notifled at

i "natural", or item edical Examiner r

27 is marked other er traumatic event, ti

permit. Pages 1 and Department of Health Important: If Item 27 any injury or other trong once.

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

O. Box 68760,

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Records.

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To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director.

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29a, Certifier

(Check only

31. Date filed (Month, Day, Year)

7.	Manner of Death		28a. Date o
	1 Natural	5 Pending	(Month
	2 Accident	investigation	
	3 ☐ Sulcide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place o

a. Date of Injury (Month, Day Year)	28b. Time of Injury		28c. Injury at Work?	
		М	1 ☐ Yes	2
e. Place of injury - At he building, etc. (Specif	ome, farm, street v)	, facto	ory, office	

28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurre

determined	building, etc. (Specify)		City or Town, State)	,
1 Certifying Physi	cian: To the best of my knowledge, death occurred at	the time, date and place	e, and due to the cause(s) and manner as stated.	

OHe)		an	a manner s	tated.
29b. Signature	and title of certifier	a.		al

29c.	License	numb	er		
	2	3	0	4	4

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

	/
9d. Date signed (Month, Day, Yea	ロフト
5-4-05	7

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1525 Greenway Said DASS

nter Dr.	309	Greenbelt	MD	SOTIC

State Registrar

Medical



10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year BOISCLAIR AROL MAY 12:14 6 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTMORE UNIVOF MANULAND MED CENTER BALTIMORE CITY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Days Hours 1 M 2 XF 146-38-2815 60 1946 PENNSYLVANIA NOV. 9, Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 XNo MARYLAND BALTIMORE PIKESVILLE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 45 HEMISON COURT 21208 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CHARLES WESLEY CONN ELIZABETH SIMONE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 45 HEMISON CT. PIKESVILLE, MD LES BOISCLAIR / HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State MAY 10, TEXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GLEN HAVEN MEM. PK. 2007 GLEN BURNIE, MD 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility KIRKLEY-RUDDICK FUNERAL HOME P.A. 421 CRAIN HWY. S.E. GLEN BURNIE, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SCPSIS 2 WEEKS Due to (or as a consequence of): 3 WEEKS FIST ULA DUODENAL Sequentially list conditions, if any, leading to immediate cause. Et al. of the cause of Clisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 7 WEEKS UPPER GI BLEED Due to (or as a consequence of): SHORT GUT 10 YEARS SYNDROME IF FEMALE:

Division or Vital Records. P.O. Box 68760.

Physician

/Medical

Examiner

Director

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show

r than "natural", or Items 23a or 28a-f shov the Medical Examiner must be notified at

death with the Maryland

filed within 72 hours after

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, the Me

Physician

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Examiner

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certificate be executed

Baltimore, Maryland 21215-0036

ysician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ ₩6 9 ☐ Unknown		pic pregnancy er <i>(specify)</i>		23d. Date of delivery Month Day Year
eted by Pr	Part II. Other significant conditions	contributing to death but not resulting in the underly	ring cause given in Part I.		se contribute to the cause of death?
Complet				24a. Was an autopsy performed? 1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
Φ	25. Was case referred to medical		26. Place of Dear	th (Check only one)	
90	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3[Other:	ome 5 Residence	6 □Other (Specify)
tification:	27. Manner of Death 1 □ Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injur	y occurred
Certific	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		actory, office	28f. Location (Street an City or Town, State	d Number or Rural Route Number,)
edical	29a. Certifier 1 CertifyIng Pt (Check only 2 Medical Example)	hysician: To the best of my knowledge, death occuminer: On the basis of examination and/or investig and manner stated.	urred at the time, date and place pation, in my opinion, death occu	, and due to the cause(s) rred at the time, date and	and manner as stated. I place, and due to the cause(s)
š	20h Signature and title of contifier		29c License number	20d Do	o signed (Month Day Voor)

17385

M44 200 7

State Registrar 31. Date filed (Month, Day, Year) MAY 0 9 2007

OF



30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RONALD TESORIERO, MD

after death

Hospital or To the Hospital within 24 hours al

k Indelible Ink Ensure All Copies Are Legible.

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21215-0036 uld be filed within 73 Mental Hygiene.	Re C.		DDIE SH		, L ast)									EASLEY					
212 buld be I Ment	T C		Informant's Na	ame/Relation														te, Zip Code)	
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teatth and Mental Hygiene. ten Z is marked other than "natural", or items 23a or 28a-f she		CA		LIVER	/ MO	THER		20b. Pla		NDOVE		etery,		Date	20	Oc. Location		or Town, State	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", Important: An annatic mark the Modical Framings	ther tr	20a. Method of Disposition 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) HOLY CROSS CEMETERY 2007 BROOM										ROOKL	N PA	ARK, MA	RYLAN				
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be. Within 24 hours after death. To the Functor: After this certificate has been signed by the attending physicial	y filled i	Series 4	✓ Homicide	e	etermined		host of my		4 - 41	curred at th	e time, da	ate and p	lace, an	d due to the	cause	e(s) and man	ner as	stated.	
the Ho	npletel	Medical 29	theck only 1	✓ Medical E	g Physicia Examiner:	On the bas	sis of exam	nination ar	nd/or investi	gation, in m	y opinion	n, death o	ccurred	at the time,	date a	ina piace, an			
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27		30). Name and a			completed o	Madical	leath (Item	23a) ner 11	1 Penn S	street. F	3altimo	re, MI	21201					
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DHMH 17 Rev 1/2001

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AMEND TIPMS perFH (2008, 5/1/07, WS)
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Year **Physician** Helen H. Benson /Medical 2887 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner YARFORD BELAIR AIR HEALTH AND REHABILITATION CENTER 8. Date of Birth (Month, Day, Year)
Feb. 20, 1 If Under 1 Year | if Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X F 82 1925 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important, if them 271s marked other than "natural", or items 272 and any Injury or other transmatic. 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits 1 □Yes 2XTNo Director Maryland Harford Forest Hill 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? 2831 Ady Road 21050 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2X No Specify: White <u>۾</u> 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John M. Harmon Laura Ray 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Laura Hefner (Daughter) 2406 Burnham Drive Fallston, MD 21047 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State May 5, 2007 Pikesville, Maryland Druid Ridge 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of Bel Air 21. Signature of Funeral Service Licensee 610 W. MacPhail Rd. Bel Air, MD 21014 Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) acciden **Physician** erl brovasca/Ar /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Errier underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed signed by the attending physician and dbe detached for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ DISTULY 1 Yes 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Jursing Home 5 Residence 6 Other (Specify) 200 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Watural 5 Pending investigation Injury To the Hospital or Attendi within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D34652 D34652 May 2 200; Bel tir Maryland 210/4 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Physician Elizabeth Naomi Bolling 7, 2007 10:25 May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 7202 Greenbank Road Middle River 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🖫 F Days Hours Min. Director 82 5/9/1924 219-14-1256 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10h County 10c. City, Town or Location 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director Middle River Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or 7202 Greenbank Road Funeral S. A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11 Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itel may injury or other traumatic event, the Medical Examines once. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. þ 3 XWidowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Clergy Pentecostal Religion 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 William Harold Kestner Naomi Pearl Gunther 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21220 JoAnne Renee Miller (Daughter) 7123 Oliver Beach Road Middle River, Maryland 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 □ Removal from State Holly Hill Memorial Gardens 2007 4 ☐ Donation 5 ☐ Other (Specify) Middle River, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue PA Essex, Maryland 21221 23a. Part1. Enter the disease, or complications that caused the eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 1cars disease or condition resulting in death) /Medical Due to (or as a consequent **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use confibute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy perforn 1□ Yes 2X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 2 1 ☐ Yes 2X No 1 | Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 2 Accident 1 Yes 2 No 24 hours after death Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Medical (Check only one) within 2 29b. Signature and title of certifier 29c. License number

State Registrar 30. Mame and address of person

0 9 2007

31. Date filed (Month

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pleted cause of death (Item

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 05 4b. City, Town, or Location of Death 4c. County of Death BAltimore rrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 10c. City, Town or Loc 10d. Inside City Limits 1 ☐Yes 2 No en 10g. Citizen of What Country 10f. Zip Code 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? Race - American Indian, 11. Marital Status Black, White, etc. Yes 2 □ s, Give r or Dates: 2 No 1 Never Married 2 Married 1 ☐ Yes 2 XNo 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Secondary (0-15) College (1-4or 5+) 19b. Mailing Address Street and Number or Rural Route Number, City or Town, Name/Relationship Koad Method of Disposition 1 Burial 2 □ Cremation 20b. Place of Disposition 4 Donation 5 Other (Specify) Address of Facility 21. Signature of Funeral Service Licensee Soseph H. BROWN, Jr. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CORONARY-ARTERY YRS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? LUNG CANCER 1 Tyes 2 No 3 Probably 4 Wonknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1∐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide

Physician /Medical **Examiner** Examiner be executed and burial-trar Box 68760,

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral Director

'natural", or items 23a or 28a-f show

within 72 hours after

Maryland 21215-0036

Baltimore,

P.O.

Division or Vital Records,

The law requires

Physician:

To the Hospital or Attending

injury or other traumatic event, the Medical Examiner must be notified at

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permit. Pages 1 and 2 should be filed a Department of Health and Mental Hygis Important: If Item 27 Is marked other any injury or other traumatic event, ##

attending physician the as asn jo the detached ģ signed þe peen has page 2:

within 24 hours after death.

To the Funeral Director: After this certificate

Physician/Medical completely filled in by the

ģ Completed Be 2 Certification:

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Medical

29a. Certifier

State Registrar 29b. Signature and title of certifier

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR DONNA -G 31. Date filed (Month, Day, Year)

2007

State of Maryland / Department of Health and Mental Hygiene

1- State Registrar Amend #1 Per Phy G867 5/16/07 Thicke of Death

Rea. No. Reg. No. 1. Decedent's Name (First, Middle, Last Busceni 2. Date of Death 3. Time of Death Day 2000 **Physician** 7:58PM Carmelo Wesley Buscimi /Medical 4c. County of Death
Baltimore 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Birthplace (State or Foreign Country) If Under 1 Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 1**⊠** M 2□ F Yrs. 05/26/1931 75 Director Maryland 213-28-7116 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location a or 28a-f show t be notified at 10a. State 10b. County 1 ☐ Yes 2 No Completed by Funeral Director Baltimore Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Iral", or Items 23a Examiner must b 2804 Glavin Way 21234 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Armed Folces:
1 Xyes 2 No
If Yes, Give Korean
Year or Dates: War 1 ☐ Never Married 2 ☐ Married Carmel Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2X No Specify: 3 ☐ Widowed 4 X Divorced White traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Salesperson United Insurance Co Buscemi 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gertrude Lee Greene Peter Anthony Buscemi 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1920 Appalossa Way - Owings, Maryland Department of Health Important: If Item 27 any Injury or other th Denise Buscemi (sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith Cem. 05/11/2007 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 21. Sign tu of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final hemorrhage subarachnoid **Physician** disease or condition resulting in death) /Medical Que to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Leet Due to (or as a consequence of) Examiner Hospital or Attending Physlcian: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, 丈 physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 **N**o 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 2 No 1 TYes 1 Inpatient Certification: To 27. Manner of Death 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No neral Director: / 2 Accident Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 ☐ Homicide within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier May 6, 2007 DØ Ø 63 Ø54 10+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Majid Cira, no, 9000 Franklinsquare Drive, Baltimore, Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

MAY 0 9 2007

ORIGINAL

Begistrar's Signature

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	/Medic Examir		4a. Facility Name (If not in				4b. City, Town,	or Location of Death		4c. County of Dea	1007 05:54P			
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	ospita hours ineral y fille	alC	29a. Certifier 1 XC	ertifying Phy	sician: To the best of	f my knowledge, de	eath occurred at the ti	me, date and place, an	d due to the ca	ause(s) and manner as	s stated.			
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Division or Vital Records, P.O. Box 68760,	the Hospital or Attending Physician: The law requirement the law requirement of the law req
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Funeral Director		Baltimore Washington Medical Center 5. Social Security Number 209-24-0365 Usual Residence of Decedent		8. Date of Birth (Month, Day, June 17	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	10a. State	10f. Zip Code 21144 3. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerlo 1 □ Yes 2▼ No Specify: Decedent's Usual Occupation we kind of work done during most of work DO NOT use retired)	ecify Yes or No- Rican, etc.)	10d. Inside City Limits 1 ☑ Yes 2 ☐ No Dg. Citizen of What Country? U.S.A. 14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry
12 should be filed v h and Mental Hygie 7 is marked other t traumatic event, th	To Be Co	17. Father's Name (<i>First, Middle, Last</i>) William S. Sheridan 19a. Informant's Name/Relationship (<i>Type. Print</i>) 19b. Ma	18. Mother's Name Laura Ro illing Address (Street and Number or Rur	eber al Route Number,	City or Town, State, Zip Code)
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	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated. 29b. Signature and title of certifier	investigation, in my opinion, death occurr	red at the time, da	use(s) and manner as stated. te and place, and due to the cause(s) d. Date signed (Month, Day, Year) Vey 4 2007
Star Registra	ar	30. Name and address of person who completed cause of death (Item 23a) (Type 31). Date filed (Month, Day, Yeal) MAY 0 9 2007 32. Registrar's Signature	Galle Brome.	mo.	21061.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Vear **Physician** Stella Sleasman Bradley 2007 May 5:05am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Brinton Woods Nursing Home Carrol1 Sykesville If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 1 □ M 2**V**□ F 93 Director 214-09-1278 Nov 11, 1913 MD Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 □Yes 2 □ No MDDirector Carroll Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 1241 Buckhorn Road 21784 USA Pages 1 and 2 should be filed within 72 hours after death 1 nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or items 23 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify Specify: þ 3 Midowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Clerical/Domestic Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Walter Brown Sleasman Effie Ross 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 I Mr. Walter S. Bradley (Son) 1313 Paul Drive, Severn, MD 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or otl 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation 5/7/2007 Sykesville, MD 21. Signature of Funeral Service Licensee HAIGHT FUNERAL HOME & CHAPEL, P.A. (Sykesville, MD 21784 (410)-795-1400 Naylot MO0764 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Riman **Physician** celculus 6 me /Medical Due to (or as a con , quenc , (f): Examiner Sequentially list conditions, it any, leading to infinitelate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se s consequence of) Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the detached 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by illusi 1 Yes 2 1√No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an ate has b autopsy perform 1 Yes 2 certificate 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Medical Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division or Vital Records, P.O. Box 68760, within 24 hours a er death

To the Funeral Director
completely filled in by the To the Hospital

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier

SUITE 102 (UENSUS)

30. Name an lad ress of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

1000 Liberty RD ELDERSBURG MD 21789

		-	For State Registrar	1 1003	State o	f M arylan		artment or rtificate			nd Me		jiene leg. No.	007	14911
w	Ohyaiai		1. Decedent's Name	(First, Middle,	Last)	· · · · · ·						2. Date of Dea Month	Day	Year	3. Time of Death 1:40 Am
	Physicia /Medic	al	GLORIA						ABAN			MAY	6	2007 ounty of Dealt	
9	Examin	er	4a. Facility Name (If HERBREW H				TON	t hirthday) If Under 1 Year If Under 24 Hrs. 8, p						ONTGOM	
1/2	Funeral	-	5. Social Security Nu		3. Sex	7. Age (In yrs.							8. Date of Birth (Month, Day, Year) 9. Birthplace (State of Country)		
44	Director		079-18-1		1 M 2 F	82						7/03/19	NY		
	land		Usual Residence of I 10a. State	10b. County		10c. Cit	y, Town or L	ocation					*		10d. Inside City Limits
	within 72 hours after death with the Maryland ene. than "neturel", or Itema 23a or 28a-f ehow the Madical Examiner must be notilised at	tor	MD	MONTGO	MERY	ROC	KVILLI	Ξ					3		1 ☐ Yes 2 ☐ No
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	fter de	Funeral	11. Marital Status 1 ☐ Never Marrie	d 2∐ Marne	Amed Fo	orces? 2 ∑ No		if Yes, specing	y Cuban,	, Mexican,	, Puerto F	lican, etc.)		Black, White	
93	rel', o	ě	3 X Widowed	Divorced	If Yes, Gi Year or D	V9		1 ☐ Yes 25		Specify:					HITE
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Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hyglene the Health and Mental Hyglene trems 23a or 28a-1 show item 27 is marked other than "neture!", or Itema 23a or 28a-1 show other traumatic event, the Madical Examiner mant be notified at	To	DAVID		S		BRAD			SARA		Courte Alumba	c City or	HERSK	
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	s 1 and f Health item 27 other tr		STEVE BA 20a. Method of Disp	osition	/ SON		Place of Disp	7 MAPL osition (Name matory or oth	of of			ate		ation - City or	
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Baltimore,	permit. Pages 1 and Department of Heali Important: if item 2 eny injury or other 2008.		21. 3ignature of Fur	INIX	Mu	gel	8		EIST	of Facility ERST(y SOL DWN F	LEVIN: ROAD -	SON 8	BROS.	, INC.
	4		23a. Part1. Enter the shock, or hear	e disease, or o	complications that	aused the deat	th. Do not er	nter the mode	of dying,	, such as	cardiac oi	respiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (disease or condition	Final	_a. M	ETA	STAT	7				CAR		KOMA	Cristi and Doalin
	/Medical Examiner		resulting in death)		Due to	(or as a consec	quence of):								
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/ita	Attending Physician: r death. ector: After this certific by the funeral director,	Be	25. Was case reference examiner?		Hospital:				Othor	-		(Check only o			
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Division of Vital Records,	ter determent	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 🗀 Could r determ	208. Flat	ce of Injury - At h ding, etc. (Speci	nome, farm, s	treet, factory,	office			28f. Location (. City or To			ural Route Number,
	Hospital or 14 hours afte Funeral Dire tely filled in t		no- Contina	15 Carristin	g Physician: To th	a bact of my kn	owledge de	ath occurred a	t the time	e date an	nd place	and due to the	cause(s):	and manner a	s stated.
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier (Check only one)	2 Medical	Examiner: On the	basis of examin nner stated.	ation and/or	investigation,	in my op	inion, dea	ath occurr	ed at the time,	date and	place, and due	to the cause(s)
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	8		30. Name and addr	ess of person	who completed call	use of death (Ite	m 23a) (Typi	o, Print) ONTR	LOS	E R	DAI	o eo	clcv	ILLE,	MD 2 485 L
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6	Regist	rar	M	AY U 9	7001 KM	THE T	17	0.4							

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 27s are any injury or other traumatic access.

Funeral

Director

Physician /Medical Examiner

Physician: The law requires that the death certificate be executed burial-transit for detached has completely filled in by the funeral director, page 2 certificate this After t or Attending Director:

Division or Vital Records, P.O. Box 68760,

1. Decedent's Name (First, **Physician** OVAM /Medical 4a. Facility Name (If not institution, give street and number) Examiner NORTHWEST HOSPITAL CENTER Birthplace (State or Foreign Country) 067-01-4992 Usual Residence of Decedent 10a. State 10d. Inside City Limits 1 ☐ Yes 2 No Funeral Director 10e. Street and Number 4730 ATRIUM COURT, 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 2 □ No 1 ☐ Yes 2 X No Specify: WHITE Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CLAIMS SUPERVISOR SOCIAL SECURITY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be BRAUNSTEIN 2 MAX TENIE AMBER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FRANCES BRAUNE / WIFE 4730 ATRIUM COURT, #452, OWINGS MILLS, MD 21117 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 Removal from State 5 Other (Specify) 05/08/2007 | REISTERSTOWN, MD 4 Donation f Funeral Service Loen 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications and caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No Yes Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 N Certification: To 1 Yes 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manuar of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item, 23a) (Type, Print han 31. Date filed (Month) Day, Year) 32 Registrar's Signature

State

Registrar

within 24 hours a Hospital

2007

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MAY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** MAY 2007 Н BLUM 7:01A SYLVIA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 7202 ROCKLAND HILLS DRIVE, #212 BALTIMORE BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 X F Yrs. 91 MD Director 218-32-4887 07/27/1915 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits show r 28a-f show notified at 1 □Yes 2 No Funeral Director MD BALTIMORE BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ms 23a or 7 7202 ROCKLAND HILLS DRIVE, #212 21209 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: r than "natural", or items the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. filed within 72 hours after 1 Never Married 2 Married WHITE Baltimore, Maryland 21215-0036 1 □ Yes 2 🗓 No Specify þ 3 Widowed 4 □ Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) INTERIOR DECORATOR FURNITURE ulth and Mental Hygie 27 is marked other I r traumatic event, the marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be HARRY **SCHWARTZ** ္ BESSIE MANKIN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a :: If Item 27 Is : or other trai 2407 SUGARCONE ROAD, BALTIMORE, MD 21209 Date 20c. Location - City or Town, State PHYLLIS CUTLER / DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name BETH EL CreMEMORTAL 1 Burial 2 □ Cremation 3 □ Removal from State Department o Important: If any injury or RANDALLSTOWN. 4 ☐ Donation 5 ☐ Other (Specify) PARK 05/08/2007 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service License 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) mhlly **Physician** Mn /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed end burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 2□No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death | Director: ... d in by the f 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1/Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

within 24 hours aft To the Funeral Di completely filled in 10

> State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year)

Convi Ad; Ad

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Barksdale 2007 6:15 AM stewart 05 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Medical Center University of Maryland If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) Days Hours 1 X M 2 □ F Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or Items 23a or 28a-f show edical Examiner must be notified at 1 Yes 2 No Director more 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: er than "natur, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) /Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, the M Once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mental 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 3 Removal from State 21. Signature of Funeral Service Licenses 222 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fullure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Diffuse Septic /Medical Due to (or as a consequence of) Examiner Endocarditis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Box 68760, signed by the attending physician the detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) Division or Vital Records, P.O. 1 Ves 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ▼No page 2 s has autopsy performed? Yes 2 No 2 No within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 TYes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 27. Manner of Death 1 ✓ Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) or Attending 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral L To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 05/05/2007 AU4176435 B17452 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

MAY 0_9 2007

Maryland

Baltimore

Registrar's Signature

54.

21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3! Time of Death Month **Physician** HARRY WILSON COLEMAN 08 2007 4:30P ^M MAY/Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** FUTURECARE-CHARLES VILLAGE BALTIMORE CITY N/A 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 213-60-6132 54 Director 06/18/1952 MARYLAND Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r 28a-f show notified at BALTIMORE MD CATONSVILLE Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hyglene. important: if item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be nonce. 5907 LEEWOOD AVENUE 21228 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. US 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes 2 No Specify. Specify: BLACK ģ ARMY 3 ☐ Widowed ★ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 BARBER SELF-EMPLOYED 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LEE GARNET COLEMAN, MAURIE AGNES WILSON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CRYSTAL C. COLEMAN/ SISTER 5907 LEEWOOD AVE., CATONSVILLE, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Removal from State METRÓ CRÉMATORY 5/10/07 CATONSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service Licer 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Cause (Final Physician Clinia menly 0 diseast or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Visus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner ending physician and use as the burial-trar Due to (or as a consequence of): attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown s been signed by the should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 nknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I autopsy 2 XNo 1□ Yes 2 NO 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Other: 25 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 TYes 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

law requires that the death certificate be executed Box 68760 o <u>م</u> Division or Vital Records, 0 Hospitai

Baltimore, Maryland 21215-0036

State Registrar

filled in by

within 24 hours a

To the Funeral I

completely filled

4 Homicide

31. Date filed (Month

29b. Signature and title of certifier

29a. Certifier (Check only one)

Thew Poon, MD, FACE

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Baltimer

D 576.88

MI) 21202

29d. Date signed (Month, Day, Year)

MAY 9, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** SANDRA Y. COSTLEY MAY 5. 2007 6:56 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Saint Joseph Medical Center Baltimore Towson 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/04/1944 7. Age (In vrs. last birthday 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 ☐ M 2 ☐ √F 228-56-6674 62 Director VIRGÍNIA Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits show r 28a-f show notified at MD BALTIMORE RANDALLSTOWN 1 ☐ Yes 2 X No Director 10e. Street and Number 10g. Citizen of What Country r Items 23a or 2 Iner must be no 21233 9612 ORPIN RD, APT. 1 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Examiner Black, White, etc. hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes ≱ No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 'natural", Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry within 72 (Give kind of work done during most of working life. DO NOT use retired) SINAI HOSPITAL Elementary/Secondary (0-12) College (1-4or 5+) OF BALTIMORE 12TH 1 and 2 should be filed w fealth and Mental Hygier m 27 Is marked other th NURSE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIAM NEWTON MILDRED NEWTON traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21233 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If Item 27 is any Injury or other trav LEONARD L. COSTLEY/HUSBAND 9612 ORPIN RD, APT 1, RANDALLSTOWN, MD Pages 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/8/07 CATONSVILLE, MD METRO CREMATORY 22. Name and Address of Facility 21. Signature of Funeral Service Licensee HOWELL FUNERAL HOME 21207 23a. Part En er Ing disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, head failure. List only one cause on each line. Immediat cause (Final disease or recondition resulting in death) a. ASYSTOLE 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of) Examiner HYPOTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical the 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 No Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. the 9 Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 No 24a. Was an Was a.. autopsy performed? 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 2 Accident 5 ☐ Pending investigation Iniurv 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide ö 29a. Certifier 1 🔀 ertifyIng PhysIcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only

24 hours after death Funeral Director: Hospital within 2. To the F

> State Registrar

KHOSROW TABASSI 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

M.D. 7601 OSLER DRIVE 32 Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

29c. License number

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29d. Date signed (Month, Day, Year)

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		1 - For State Registrar	State of M				te of L				eg. No.			
Physici	an	Decedent's Name (First, Middle, L.	ast)					_	2	. Date of Dea Month	th Day	Year	3. Time of Death	
/Medi		Patricia					(loud		May	5	2007	4:13 A	
Examir	ner	4a. Facility Name (If not institution, g The Johns Hopkins A	lospital			Balt	/, Town, or Morc er 1 Year	City If Under 2			BA	County of Death	CITY	
uneral irector		5. Social Security Number 6. 298-38-4670 Usual Residence of Decedent	Sex 7. Ag 1 □ M 2/CX F	60_	last birthday) Yrs.		Days	Hours	Min.	Date of Birth (Month, Day AY 18,	Year) 194	Col	place (State or Forei intry)	
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s 23a or 28a-f ehow ust be notified at	Director	MARYLAND HOWARI)	C	OLUMBI <i>I</i>		- 0-4-				0- 00	(147)	1 ☐ Yes 2 \ \\	
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Hygiene. yther than "natural", or tems 23a or 28a-f ehow ent, it is Medical Examiner must be notified at	Completed b	3 ☐ Widowed 4 ☑ Divorced 15. Decedent's I (Specify only highest g	Year or Dates: Education rade completed)		16a. Deced	kind of w	ual Occupa rork done d use retired	uring most	of working		16b. Kir	BI nd of Business/I	ACK	
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e ma		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Addre	ss (Street a	nd Number	r or Rural F	Route Number	r, City or	Town, State, Z.	ip Code)	
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it: If Iten y or oth		20a. Method of Disposition 1 □ Butial 2 ☑ Cremation 3 4 □ Donation 5 □ Other (Spec		0	lace of Dispo emetery, cren FRO CRE	sition (Na natory of	ame of other place	9) M	Dat AY 9, 2007		20c. Loc	cation - City or 1	own, State	
important: If Ite any injury or otl once.		21. Signature of Furence Service Light	^	PIIS.	22	Name :	and Addres	s of Facility	,	RAL HOI GLEN B				
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sician edical		23a. Part1. Enter the disease, or co- shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)	y one cause on each li	ne.		er the mo	ode or dying	, such as c	ardiac or r	espiratory arr	est, 		Approximate Interval Between Onset and Death	
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physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to introduct cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	c. MRSA b Due to (or as										30 days	
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signed d be del	þ	Part II. Other significant conditions Diabetes mellitus	contributing to death b	ut not res	ulting in the ur	derlying	cause give	n in Part I.		23e. Did tot			the cause of death?	
2 shoul	Completed	Hypertension								24a. Was a	n	24b. Were aut	opsy findings availab	
page 2	mo.	End Stage Reval Dis								autops perforr 1 Yes	med?	death?	ompletion of cause of 2□ No	
is certificet director, pa	Be	25. Was case inferred to medical examiner?						26. Place	of Death (Check only on				
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To the Funeral Director: , completely filled in by the f	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, str							Location (St City or Town		Number or Rui	al Route Number,	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		l- For State Registrar			Certific	ate of l	Death			Re	g. No.	Bana 'we'	V 1		
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ledical Examii	ner	Rebecca Caudel	1						M	ay 1, 200	07°	1 cai)727 hrs	
		4a. Facility Name (if not institution	_	umber)			. City, Town, or Lo	ocation of D	Death			unty of D	eath		
		Schuster Rd. &Jarrett	sVille Pike				Jarrettsville					ford			
Funeral		5. Social Security Number	6. Sex	7. Age (In	yrs. last birt	thday)	If Under 1 Year				100		ce (State or		
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	ŀ	Usual Residence of Decedent													
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21215-0036 and be filed within 77 Mental Hygiene. marked other than c event, the Medical	ompleted	12		4	Set	nior	Lab Tech						pkin	s Lab	
5-0 Hed w Hygi	9	17. Father's Name (First, Middle	, Last)				18	B.Mother's N	Name (Firs	st, Middle, M	Maiden Sur	name)			
21 be fi ental rrked	å	John A. Hild,	Jr.					Susan							
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Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other thinjury or other traumatic event, the Med		21. Signature of Funeral Service	Licensee			22. Na	me and Address o	of Facility S	chim	ınek E	unera	1 Ho	me o	f Bel Air	
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Physician		23a. Part I. Enter the disease, or failure. List only one cause		caused the	death. Do no	ot enter the	e mode of dying, s	uch as card	diac or res	piratory arr	est, shock,	or heart		pproximate Interval Between Onset and	
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Division of Vital Records, tal or Attending Physician: The law requir rs after death. al Director: After this certificate has been siled in by the funeral director, page 2 should the fine of the funeral director.	Certification:	dete	ld not be		Road / H		, , , , , , , , , , , , , , , , , , , ,		- 1	or Town, S	State)			rrettsville, MD	
Division of Vital Records, P.O. Box 68 Hospital or Attending Physician: The law requires that the death certif 24 hours after death. Funeral Director: After this certificate has been signed by the attending		4 Homicide 29a. Certifier 1 Continue B	hysician: To the b				ed at the time dat	e and place	- 1						
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical		miner:On the basi	s of examin										use(s)	
5 W 5 0	ě	29b. Signature and title of certifi	er /	stateo.			29c. License	number			29d. Dat	e signed	(Month,	Day, Year)	
		Mlan Brass	IL AN				O.C.M	1.E.			May 2	, 2007			
		30. Name and address of person	who completed ca	use of deat	h (Item 23a)										
10		Melissa Brassell, MD	Assistant M			111 Pe	enn Street, Ba	altimore,	MD 212	201					
,	ate	31. Date filed (Month, Day, Year)	32.	gistrar's	Signature	<i>a</i> .					-				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** CROGAN 11;45 PM GLORIA 75 /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE CITY MED CTR BALTIMORE, MD UNIV OF MARYLAND If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** 1 M 2 F 216-36-9800 106/193 Director Pennsylvania Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Item 27 is marked other than "natural", or Items 23s or 28s-t show other traumatic svent. The Madical Examples must be notified at 1 ☐ Yes 2 ☑ No Directo Pennsylvania York Fawn Grove 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 387 Garvine Mill Rd 17321 U.S.A. Funerai death . Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 2 should be filed within 72 hours after and Mental Hygiene.

Is marked other than "natural; or ite 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12 Settlement Coordinator Title Company 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: It Item 27 is marked other any injury or other traumatic event, 9DRs. 17. Father's Name (First, Middle, Last) Be Frank Saynuk Jean Lauri 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Crogan (Husband) 387 Garvine Mill Rd Fawn Grove, PA 17321 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 1 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 5-7-2007 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Schimunek Funeral Home of Bel Air Kineker Inc. 610 W. MacPhail Rd. Bel Air, MD 21014 LO. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final lymphoproliferative **Physician** Due to (or as a consequence of): disease or condition resulting in death) Post months /Medical Examiner leas Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consence of) Examiner I Hecords, P.O. Box 68760, The law requires that the death certificate be executed non-alcoholic Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physicien for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Year Month Day 4 Pregnant at time of death 5 Other (specify) ned by the a 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No this certificate has 2 No 1 Yes 1 Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 npatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 2 ER/Outpatient 3 DOA Đ 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident in by the Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a, Certifier 29b. Signature and title of continu 29c. License number 29d. Date signed (Month, Day, Year) AU4176435B17559 4/2007 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PEPTOF - 22 S GREENE ST/BALTIMORE, MD/21201 MD MICHAEL BREWER SURGERY 32. pgistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

MAY 09

2007

ORIGINAL

		Please Type or Print in Black Indelible Ink. Ensure A	-	_	
	4	State of Maryland / Department of Health and N	Mental Hygie	e ne 7	11.020
		Registrer Certificate of Death		J. No U U /	1 + 0 4 0
Physician /Medical		1. Decedent's Name (First, Middle, Last) LORETTA CAMPBELL	2. Date of Death	Day 2007	3. Time of Death
Examiner		4a. Facility Name (If not inevitution, give street and number) ABOLTY AND GENERAL HOSPITAL 4b. City, Town, or Location of Death BOLTI MOVE (1+1)	1	4c. County of Death	
Funeral Director		5. Social Security Number 6. Sex 1 M 2 Set 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hgs. 7. Age (In yrs. last birthday) Wonths Days Hours Min.	8. Date of Birth (Month, Day,)		place (State or Foreign http) RVLAND
yland	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		1	0d. Inside City Limits
d 21215-0036 d 21215-0036 filled within 72 hours after death with the Maryland Hygiene. when then "natural", or iteme 23s or 28s-1 show bint, the Maryland Eraminar must be notified at the Completed by Funeral Director		MARYLAND N/A BALTIMORE 10e. Street and Number 10f. Zip Code		Citizen of What Cour	1/S Yes 2 □ No
th with 23a or ust be r		1520 WEST NORTH AVENUE 2121	7	USA.	my:
S titler death viriteme 23 ciner must	5	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes 2 No	pecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	ean Indian, etc.
5-0036 72 hours after natural; or lated by F	2 20	3 ☑ Widowed 4 □ Divorced If Yes, Give Year or Dates: 1 □ Yes 2 ☑ No Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation	16	Specify: BL	ACK dustry
21215-00 21215-00 ed within 72 hou yejenen ser han "nature is tre Medical E		(Specify only highest grade completed) (Give kind of work done during most of work life. DO NOT use retired) (Give kind of work done during most of work life. DO NOT use retired)	king		~ t. t.
			OKKER UI ne (First, Middle, Ma		FMD
Z Banda Za		FRANK S. TOWNES PEA. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rur	LA	Situar Tourn State Zir	MALL
~2 5 g Z Z	18	ROMINA D. CAMPBELL (DAUGHTER) 619 N. BENTALOUS	T. BALT.	IMORE, MO	,21216
0 8 2 2 2		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place)		Oc. Location City or To	own, State
Baltimo permit. Pag Department Importent: I any injury o	-	21. Signature of Funeral Service Incensee 22. Name and Address of Facility	NWN JI	R. FUNER	AL HOME
	1	23a. P. V. Enter IVI disease, or complications that callsed the death. Do not enter the mode of dying, such as cardiac stock, or hear failure. List only one cause on each line.		ALTIMORE	Approximate
Physician	d	Immurate Cause (Final displayed or condition resulting in death)			Interval Between Onset and Death
/Medical Examiner		Due to (or as a consequence of):			
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6876(ifficate be g physicia as the bu		d			
P.O. Box 687 nat the death certificate I d by the attending physis letached for use as the t Physician/Medica		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy		23d. Date of deliver	ory Day Year
P.O. I that the de add by the additional the additional the additional that the additi	-	1 ☐ Yes 2 ☑ No 9 ☐ Unknown 9 ☐ Unknown			
rds, Figures that a signed and be der		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		cco use contribute to the	ne cause of death?
Il Record The law requir cate has been si page 2 should			24a. Was an autopsy	24b. Were auto	psy findings available impletion of cause of
Vital Rediction: The tractor, page		25. Was case relerred to medical 26. Place of Deat	performe 1 ☐ Yes 2 € th (Check only one)	d? death? No 1 ☐ Yes	2□ No
of Vital hysiclen: his certifics I director, is		examiner?		ce 6 ☐Other (Specify	y)
Division of Vital Records, of or Attending Physician: The law requires taller death. Director: After this certificate has been signed in by the funeral director, page 2 should be certification: To Be Completed by		27. Manner of Death 1	28d. Describe how	injury occurred	
Division C tel or Attending P rs after death. el Director: After I ed in by the funera Certification:		3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stree City or Town,	et and Number or Rura State)	l Route Number,
Division of Vital Records, P.O. Box 68760,— To the Hospital or Attending Physician: The taw requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the tuneral director, page 2 should be detached for use as the burial-transit Medical Certification: To Be Completed by Physiclan/Medical Examil		29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, or examination and/or investigation, in my opinion, death occur and manner stated.	and due to the cau	se(s) and manner as si a and place, and due to	ated. the cause(s)
To the complex	-	one) and manner stated. 29b. Signature and title of certifier 29c. License number	290	Date signed (Month,	Day, Year)
,	-	30. Name and address of person who copyplated cause of death (Item 23a) (Type, Print)	10 M	ay 06,	1007
		Mahabad Som lavad: MD CIN Manilon (ienera	1 Hospita	7/
State Registrar		31. Date filed (Month, Day, Year) MAY 0 9 2007		,	

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Patrio	Patricia Leona Cassell State of Maryland / Department of Health and Mental Hygiene Certificate of Death Per No. 2 0 0 7 11 0 0									100						
	Ph	nysicia		Registrar 1. Decedent's Name	(First, Middle,Last)	· · · · · · · · · · · · · · · · · · ·	`	Jorunouto c	,, ,	- Cutin		2. Date of De). 2º 1 1	3. Time of De	eath
Med		Exami		PATRICIA	L. CASSE	.I.						Month April 23,	Day 2007	Year	2110 hrs	
				4a. Facility Name (if	not institution, give	street and no	umber)			City, Town, or Lo	ocation of Deat		4	c. County of De	ath	
\$. J				9654 Hastiпç						Columbia				Howard		
. 3		neral ector		5. Social Security Nu	umber 6. Sex		7. Age (In y	rs. last birthday)	_	f Under 1 Year Months Days	If Under 24Hr Hours Mir		irth(MM	Fo	Birthplace (State of	or
	Dire	ector		UNKNOWN		M 2 XF		95 Yr			110010	JAN. 1	8		Country)	RERIA
		ny		Usual Residence of 10a. State 1	Decedent 10b. County		10c.	City, Town or Loca	ation						10d. Inside Ci	ity Limits
	-P	how a		MD	HOWARD			COLUMBIA							1 X Yes 2	•
	arylan	8a-fs at on	Director	10e. Street and Num				COLUMBIA		of. Zip Code			10g. Cit	tizen of What C		
	he Ma	or 2	Q e	9651 HAS	STINGS DR					21045		- 1	т.	IBERIA	,	
with t				11. Marital Status	JIINGO DIC	12. Was De	cedent Ever	in U.S. 13. W	as De	ecedent of Hispa	anic Origin? (S	pecify Yes or N		14. Race - An	nerican Indian, Bla	ack,
	death	or items 23a or 28a-f show any must be notified at once.	Funeral	1 Never Marrie	d 2 Married	Armed F	orces?	to If		specify Cuban, I	Mexican, Puerto	o Rican, etc.)		White, etc.		
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	hours	'natu Exam	eq	15. Decedent's Edu				d) 16a. Decede during r	ent's L most o	Jsual Occupation of working life. D	n (Give kind of DO NOT use re	work done tired)	16b.	Kind of Busine	ss/Industry	
	36 iii 72	than "	ple	Elementary/Secon	ndary (0-12)	College (1-4 or 5+)			DOMES	STIC		D_0	OMESTIC		
:	5-0036 lled within 7	ther t	Completed	17. Father's Name (F	First, Middle, Last)				-	18	3.Mother's Nam	e (First, Middle,				
	215 e file	ked o	Be (SAMMIE S	MITH SR.						UNKNO			,		
	2121 lould be fi	s mar	임	19a. Informant's Nan		oe, Print)		19b. Mailir	ng Ad	dress (Street a			mber, C	City or Town, St	ate, Zip Code)	
	more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland	Department of realin and Mental rygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner			N CASSELI	/GRANI		1836	_M	ETEZERO	ΓΤ RD.	#1922 H	YAT	<u> ISVILLE</u>	MD. 2078	83
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:	Baltimore, permit. Pages 1 at Department of He	mpor		21 Signature of Fun	eral Service Licens	e l	00			e and Address o	•				D.C. 200	
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	Physi -/Med	ıcıan dical		failure. List only	one cause on eac	n line.)				or respiratory ar	rest, sn	ock, or neart	Approximate Between On	nset and
	Exam	niner		Immediate Cause (F or condition resulting			ve Athero	sclerotic Card	liova	ascular Dise	ase			_	Deat	,n
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Ì	7.6 ficate	g phys		IF FEMALE: 23b. Was decedent p	regnant in the	23c. If yes,	outcome of p		_4_1_4		Ectopic pregna		23	d. Date of deliv		
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(E E	ಹ, ನಿ.	by P	Part II. Other signific	icant conditions	contributing to	o death but n	ot resulting in the	unde	rlying cause give	en in Part I.				to the cause of de	
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	ord	has been s 2 should l	Completed									24a. Was auto	psy	prior t	autopsy findings a o completion of ca	
	The la	cate h	틹										ormed? 2 ✔ N	death	? Yes 2	No
		his certificate l director, page	Be	25. Was case referre examiner?	-						Death (Check	only one)				
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	DIVISION OF VITAL RECORDS, tal or Attending Physician: The law require 18 after death.	After the funeral	ᇹ	27. Manner of Death1 Natural	5 Pending	28a. Date (Month	or injury n, Day,Year)	28b. Time of	Injury		at work?	28d. Describe	how inj	ury occurred		
:	ISIO Atten	Director: Lin by the	cati	2 Accident	Investigation	28e Plac	e of Injury - 4	At home, farm, stre	et fa			28f Location (Street	and Number or	Rural Route Numb	or City
i	tator Tsaffe	reral Director:	ertification	Dalage	6 Could not be determined	(Specify)	o or injury 7	it nome, idini, oue	, iu	otory, office built	dirig, ctc.	or Town, S		and Number of	Autai Route Numb	ier, City
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	F 3	F 3	ĭ	29b. Signature and ti						29c. License n	number	-	29d.	Date signed (A	nonth, Day, Year)	
O.C.M.E. April 2								il 24, 2007								
4	30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201															
\sim				Laron Locke 31. Date filed (Month)		- 600	egistrar's Sign		ı Str	eet, Baltimo	ore, MD 212	רטז				
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Physici /Medi		1. Decedent's Name (First, Middle, I	ndreu) (α I	rtificate of Dea 24+har		2. Date of Dea	Reg. No.	Year 07	3. Time of Death	
Examir Funeral Director		4a. Facility Name (If not institution, g VA M C i C a 5. Social Security Number 219-48-9861	1 Cente		ast birthday) Yrs.	4b. City, Town, or Loca To If Under 1 Year If U Months Days Ho	ation of Death M D Under 24 Hrs. ours Min.	8. Date of Birt 049319		9. Birthp	lace (State or Foreign try)	
ס	tor	Usual Residence of Decedent 10a. State 10b. County MD Howard		_	, Town or Lo	ocation				1	0d. Inside City Limits	
with the 3a or 28e	Il Direc	10e. Street and Number 5904 Waterloo Rd	•			10f. Zip Code 21045			10g. Citizen USA	of What Coun	try?	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or items 23a or 28e-f show may injury or other treumatic event, the Midrial Examinational be instiffed at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Amed Forces? I DET es 2 1 1 1 Yes, Give Year or Dates:		If Yes, specify Cuban, Mexican, Puerto Rican, etc.)					Race - Americ Black, White, ecify: Cauc	etc.	
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and 2 should in a 27 is marke near treumatic		19a. Informant's Name/Relationship Angeline D Lockle				ng Address (Street and N waterloo Ro					Code)	
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permit. Departm Importe any inju		21. Signature of Funeral Service Lic	Censee	NUU		remation and 717 Green Pas				re, Mary	yland 21286-	
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 ☐ Fetal death 3 ☐ Ectopic pregnancy						23d. Date of delivery Month Day Year		
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ding Physicial h. After this certi	on: To Be	25. Was case deferred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	Hospital: 1 Xînpatie 28a. Date of Inju (Month, Da		ER/Outpatie 28b. Time o Injury	nt 3 DOA Other: 4 If 28c. Injury at Work?	Nursing Hor	n <i>(Check only o</i> me 5 Resid 28d. Describe h	dence 6		')	
or Attend after death Director: /	Certification:	2 Accident investigat 3 Suicide 6 Could no 4 Homicide determine	t be	ury - At ho c. (Specify	me, farm, st	M 1 ☐ Yes		28f. Location (S City or Tox		umber or Rura	l Route Number,	
Hospital 24 hours a Funeral etely filled	edical Co	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best aminer: On the basis of and manner sta	f examinat	wledge, deat ion and/or in	th occurred at the time, dance to the time, dance t	ate and place, and death occurre	and due to the ed at the time,	cause(s) and date and pla	d manner as stace, and due to	ated. the cause(s)	
To the within To the compl	Me	29b. Signature and title of certifier	De	7	110	29c. License nun	mber		29d. Date si	igned (Month,	Day, Year)	
3+1		30. Name and address of person w	completed cause of g	ath (Item	23a) (Type,	Print) Medreal	Cento	C. P	attin	ore A	AD.	
St Regist	ate rar	31. Date filed (Month, Day, Year) MAY 0 9	2007 32 legistr	ar's Signa	ture Ap	cele	- 7.77					

			For State	State o	of Maryland		irtment of H			, ,	20	07	111023
	-		Registrar 1. Decedent's Name (First, Middle	(last)		Cer	illicate of L	Jeani		. Date of Deat	eg. No. 💪 🔱	41	3. Time of Death
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<u>,</u> , 1	Examin		4a. Facility Name (If not institution		,		4b. City, Town, or	Location	of Death		4c. County	of Death	
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	uneral rector		5. Social Security Number 215-05-2677	6. Sex 1 ☐ M 2 ☐ xF	7. Age (In yrs. In 91	as <i>t birthday)</i> Yrs.	Months Days	Hours	Min.	Date of Birth (Month, Day, arch 2,	Year)	9. Birthr	place (State or Foreign htry) PA
	rector		Usual Residence of Decedent						FI	alti Z,	1910		FA
yland	at	. [10a, State 10b. County		10c. City	, Town or Lo	cation					1	Od. Inside City Limits
e Mar	la-f sl	cto	MD Balt:	imore		Reist	erstown	_					1 □Yes 2√□No
ith th	or 28	Director	10e. Street and Number				10f, Zip Code			10	0g. Citizen of W	/hat Coui	ntry?
ath w	s 23a nust l		30 Caraway 1		-d	0 100		1136	-i-i-2 /Ch	f. V N -		USA	can Indian,
ter de	item ner n	Funeral	11. Marital Status 1 □ Never Married 2 Marr	Armed F	edent Ever in U.Sorces?	5. 13.	Was Decedent of Hi f Yes, specify Cuba	ispanic Or an, Mexica	an, Puerto Ri	can, etc.)		k, White,	
filed within 72 hours after death with the Maryland Hygiene.	ral", or items 23a or 28a-f show Examiner must be notified at	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, G Year or D	ive		I∐Yes 2. No	Specify	<i>'</i> :		Specify.	· W]	nite
2 ho	ical E	Completed	15. Decedent	t's Education		16a. Deced	lent's Usual Occup kind of work done o	ation	st of working		16b. Kind of Bu	siness/In	dustry
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be fi	ed otl	Be	17. Father's Name (First, Middle,	,				TO. IVIOUS	. '	ria Unl		<i>e)</i>	
hould d Me	mark	은	George Sterne 19a. Informant's Name/Relations			19b. Mailir	g Address (Street	and Numb				State. Ziu	Code)
d 2 s	27 Is r trau		Sharon G. Call		ghter		araway Ro				-	1136	
s 1 au	item		20a. Method of Disposition		20b. P	lace of Dispo	sition (Name of natory or other place	e)	Dat	te :	20c. Location -	City or To	own, State
Page Pent c	int: #		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		i State		Mem. Par		5/9/0	7	Parkv	ille	, MD
permit. Departn	Important: If item 27 Is marked other than "natur any injury or other traumatic event, the Medical I once.		21. Signature of Funeral Service	Licensee Qo	nK'		Name and Addres		. т		eisters		Road 21136
			23a. Part1. Enter the disease, or	complications that	caused the death							1111	Approximate
Phy	sician		shock, or heart failure. List Immediate Cause (Final	only one cause on	leach line.	Mp	tastas	SPC					Interval Between Onset and Death
/M	edical		disease or condition resulting in death)	Due to	(or as a consequ	uence of):	tastas	^				_	
Exa	miner		Se wentially list conditions,	b. Ai	RENA		ANCE	2					marths
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th cer	attending ph for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		itcome pf pregna birth 2 ☐ Fetal		Ectopic pregnancy	,			23d. Date		
e dea	the att	sici	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknowh		nant at time of de		Other (specify)				Moi	ntn	Day Year
hat th	signed by the s be detached 1	Ph	Part II. Other significant condition	ons contributing to	leath but not resu	ulting in the u	nderlying cause give	en in Part	ī	23e. Did tob	pacco use contr	ribute to t	he cause of death?
The law requires that the death certific	signe d be c	d by	an in onior organization			g	,g g			1 □ Ye		3 ☐ Pro	
S ed	should t	Completed								24a. Was a	n 24b. V	Nere auto	opsy findings available
he la	S 62	ш								autops perfort	ned? r	orior to co death?	impletion of cause of
a ::	tificat tor, pe	Be C	25. Was case referred to medica	ı				26. Plac	ce of Death (1 Yes 2 Check only on		□Yes	2 NO
ysic	direc	To B	examiner? 1 ☐ Yes 22 No	Hospital: 1 □	Inpatient 2	ER/Outpatier	nt 3 DOA Oth	er: 4□N	lursing Home	e 5 ☐ Reside	ence 6 10th	er <i>(Speci</i>	y) HOSPICE
2 E	ifter th		27. Manner of Death 1 Natural 5 □ Pendin		of Injury nth, Day Year)	28b. Time o Injury	Wor			d. Describe ho	w injury occurr	ed	
tendi leath.	tor: A	cati	2 Accident Investig	gation	a affinition. At he			Yes 2 □		· · · · · · · · · · · · · · · · · · ·			10 1 N
or At	Direc in by	Certification:	4 Homicide determ	nined 28e. Plac build	ding, etc. (Specify	y)	eet, factory, office		28	City or Town	reet and Number, State)	er or Hun	al Route Number,
spital	neral / filled			ng Physiclan: To th									
To the Hospital or Attending Physician: within 24 hours after death.	To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical	(Check only 2 Medical one)	Examiner: On the and ma	basis of examina nner stated.	tion and/or in	vestigation, in my o	opinion, de	eath occurred	d at the time, d	ate and place,	and due i	to the cause(s)
Tot	To t	Ž	29b. Signature and title of certifie		000		29c. Licens				9d. Date signed	d (Month,	Day, Year)
)	7		Xendell	LKIa	ulle	16	104:	264	75		<i>5/0</i>	6/0	100 /
	H		30. Name and address of person	WENES M	ise of death (Item	1 23a) (Type,	scrterer	Blu	sd/8	celfo M	uD 20	20	4
	Sta Registr		31. Date filed (Month, Day, Year)	2007	Registrar's Signa	ture	W						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 3 Day **Physician** Month May 2007 IRENE CREIGHTON 10:00 pm /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Columbia

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)
Aug. 27, 1 Sunrise of Columbia Howard Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 □ M Delaware Director 1925 222-12-5099 81 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or hiems 23a or 28a-f show unty or other traumatic event, the Medical Examiner must be notified at 10a. State 10h. County 10c. City. Town or Location 10d. Inside City Limits r 28a-f sh notified 1 ☐ Yes 2 ☐ No Director Delaware New Castle Newark 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 1205 Independence Way, Southridge 19713 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XX o Specify. Completed by XXWidowed 4 □ Divorced Specify: White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12)
Grade 12 College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harlan Hinman Nellie Stoeckel ۵ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kristine C. Bloom daughter 10656 Glass Tumbler Path Columbia, Maryland 21044 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 Ă Pemoval from State 4 ☐ Donation 5 ☐ Other (Specify) DE Veterans Mem Cem 5/7/2007 Bear, Delaware 21. Signature of Euneral Service Licensee 22. Name and Address of Facility
Donaldson Funeral Home, P.A. M00770 313 Talbott Avenue Laurel, Maryland 20707 23a. Part1. Enter the disease, o shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, pnly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) 2 days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 XNo detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Minknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 【X Xo certificate 1□ Yes 2XXo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Assisted Other: 4 Nursing Home 5 Residence 6XX ther (Specify) 1 ☐ Yes 2 ☐ X Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To filled in by the funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No hours after death. 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Hospital 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 110TY Letter BA 37 Registrar's Signature 31. Date filed (Month, Day, Year) State

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Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Day Corbin 2010 M 26 200 Va /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE N/AUNION MEMORIAL HOSPITAL If Under 1 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) **Funeral** Hours Days 1 ☐ M 2 ☑ F 49 214-73-0058 Director 12-24-1957 WEST VIRGINIA Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1 XYes 2 ☐ No Director N/A BALTIMORE MD. 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code 115 N. HIGHLAND AVE. Funeral "natural", or Items 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: WHITE Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CASHIER STORE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be finent of Health and Mental I int: If Item 27 Is marked o ပို BUDDY PRICE BETTY DEBORD 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WAYNE G. CORBIN (HUSBAND) 115 N. HIGHLAND AVE. BALTIMORE, MARYLAND 21224 Item 27 Baltimore, 20a. Method of Disposition

1 Burial 2 Tematio 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages Department of Important: If It any Injury or o 3 □Removal from State 4 □ Donation Other (Specify) METRO CREMATORY 4-30-2007 BALTIMORE, MARYLAND THAM HIBNER. Name and Address of Facility REDD FUNERAL SERVICE 2 4721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part1. Ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate ause (Final disease of ondition resulting in death) 2 day Physician meumonic /Medical Due to (or as a consequence of) Examiner uva e-1510V Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the death certificate be executed burial-trar Due to (or as a consequence of): Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 | Yes 2 | No 3 | Probably 4 | Vonknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a, Was an autopsy page 2 No certificate 1∐ Yes Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this funeral 27. Mannef of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Al completely filled in by the fu

> State Registrar

4 Homicide

(Check only one)

30. Name and

29b. Signature and title of certifier

31. Date filed (Month, Day,

ddress of person who completed cause of death (item 23a) (Type, Print)

M.D

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month a7 COPES April 22:15 M Nable /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore The Johns Hobkins Hospital If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 ☐ M 2 🔀 F 28, MD Director 214-44-3323 61 AUG. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene.
Int: If item 27 is marked other than "natural", or items 23a or 28a-f show Inty or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1XYes 2 No Directo BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2417 E. MADISON ST 21224 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by Specify: Specify: BLACK 3 ☐ Widowed 4 X Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12TH DAY CARE CITY of BALTIMORE injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ CHARLES H. GROSS ANNIE B. McCAIN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trai 809 GORSUCH AVE., BALTIMORE, MD 21218 ALEGRA COPES 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 5500 O DONNELL St. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/04/2007 BALTIMORE, MD TRINITY 21224 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. 21. Signature of Funeral Service Lice 2007-09 EASTERN AVE., BALTIMORE, MD 21231 Part I. Enter the discase, or complications that caused the de the Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) irculatory **Physician** 1 week /Medical e of): Due to (or as a conseq **Examiner** pertersion Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed physician and the burial-transit Sclerodorma Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical as the t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown r signed by ti Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 ☐ Pending investigation ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a

To the Funeral I 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hansie Mathelier, The Johns Hopkins Hospital, 6000 North Wolfe Street, manyland

medical Doctor

32. Jegistrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 29 2007 James Darrell Campbell 1505 /Medical 4c. County of Death
Baltimore City 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner **Baltimore City** Union Memorial Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Month, Day, Year | May 29, 1928 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Country) Arkansas 1 M 2□F Months 78 220-20-3540 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location if than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Ellicott City Howard Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21043 3510 Belfont Dr. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene.
7 Is marked other than "1 Elementary/Secondary (0-12) College (1-4or 5+) Accounting CPA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thelma Mei Johnson Virgil Campbell 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3510 Belfont Dr. Ellicott City, Maryland 21043 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other trai once. Wife Mrs. Katherine Campbell 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 05/04/07 Marriottsville, Maryland Crest Lawn Memorial Gardens 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Slack Funeral Home, P.A 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Eist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** rneu monia disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner ENTIL weeks Shock Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy detached for Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ page 2 should be 3 Probably 4 ☐ Hiknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy this certificate 2 No 1□ Yes the Hospital or Attending Physician: hin 24 hours after death. director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 2 00 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) funeral 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident completely filled in by the Director: 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie AT2438946 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Union Memoral Hospital, mo MD manchar 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	Otate of Ivial		ertificate of			eg. No.	7 14928
В	Physici	an	1. Decedent's Name (First, Middle, La					2. Date of Deat Month	h Day Yea	3. Time of Death
1	/Medic	al	4a. Facility Name (If not institution, giv		Leroy Co		or Location of Death		May 6, 2007 4c. County of D	2:20 p. ^M
ph.	Examin	er	-	Gilchrist Hospice	Center	15. Oxy, rown,	, 200dioi, oi 20di	Towson		Baltimore
	Funeral Director		010 20 00 10	Sex 7. Age 7. Age	(In yrs. last birthda 77 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, July	Year) 29, 1929	Birthplace (State or Foreign Country) Indiana
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location		<u></u> -w.		10d. Inside City Limits
Maryland 21215-0036	he Maryl 28a-f sho otiffed a	ector	Maryland 10e. Street and Number	Howard		10f. Zip Code	Ellicott City	11	0g. Citizen of What	1 □ Yes 2 No
	ath with the 23a or inst be n	Funeral Director	3004 North Ridge				21043	3		U.S.A.
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 □ Never Married 212 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: ~	1955	3. Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 ☑ No	Specify:		Black, W	merican Indian, /hite, etc. White
15-0	"natu	letec	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Dec	edent's Usual Occu le kind of work done . DO NOT use retire	pation during most of wor	rking	16b. Kind of Busine	ess/Industry
121	withir iene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		iathematiciar		Nation	al Security Agency
Jd 2	ould be filed withi Mental Hygiene. arked other than atic event, the M	Be C	17. Father's Name (First, Middle, Last		<u> </u>		18. Mother's Nan	ne (First, Middle, M		
ylaı	should be nd Mental marked c	_C	·	ne Ross Conn	T. 401. 14	"- Address (0)			ed Mae Gross	
	: 1 and 2 sho Health and tem 27 Is ma		19a. Informant's Name/Relationship (Son		Rock Dr. Elli	cott City, Mai	yland 21043	
Baltimore,	Pages 1 nent of He int: If iten		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci		cemetery, ca	position (Name of rematory or other pla Hartford City C		05/10/07	20c. Location - City Ha	or Town, State artford City, IN
Balti	permit. P Departm Importar any Inju		21. Signature of Funeral Service Lice	nsee Pholips	N (1003	22. Name and Addr		ome, P.A.	ott City, MD 2	4040
			23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final			nter the mode of dy	ing, such as cardiad	or respiratory arre	off City, MD 2 est,	Approximate Interval Between Onset and Death
N. M.	Physician /Medical Examiner		disease or condition resulting in death)	U	consequence of):	IX.	(ta) t			years
L		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a	consequence of):					
ó	tificate be executed ig physician and as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	consequence of):					
68760,	ate be	Medical		d						
.O. Box 6	ath cer ttendir or use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome p 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	Fetal death	B□Ectopic pregnand □ Other (specify)	су		23d. Date of Month	delivery Day Year
<u>α</u>	uires that the de signed by the a Id be detached f	by	Part II. Other significant conditions	contributing to death but	not resulting in the	underlying cause gi	ven in Part I.	23e. Did tob	\ .	e to the cause of death?
Records,	law requir as been si 2 should I	Completed						24a. Was a	n 24b. Were	e autopsy findings available to completion of cause of
E B	The law	Com						perform	med? deat 2. Mo 1 □	h?
or Vital	hysician: Th his certificate I director, pag	Be	25. Was case referred to medical examiner?	Hospital:		0T PO. Ot	has	ath (Check only on	1	1
ō	ding Phys I. After this funeral di	5 E	1 ☐ Yes 200 No 27. Manner of Death	28a. Date of Injury	/ 28b. Time	of 28c. Inju	4 LI Nursing F		ence 6 ther (s	Specify) Nospico
ion	ath. or: Afte	atior	1)☑Natural 5 ☐ Pending investigation		Year) Injur		Yes 2 No			
Division	al or Atte	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		y - At home, farm, (Specify)	street, factory, office		28f. Location (St City or Town		r Rural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director, it	Medical C		hysiclan: To the best of miner: On the basis of and manner stat	examination and/or					
	To th Vithir To th	Me	29b. Signature and title of certifier				se number		9d. Date signed (M	lonth, Day, Year)
	8x1		30. Name and address of person who	completed cause of de	ath (Item 23a) (Typ	· · ·		son m	> 21204	,
	Sta	ate	31. Date filed (Month, Day, Year)	32. Regiştrai	r's Signature	1-0-	31 1000	ADI A V.	, 5, 5, 7	
	Regist		MAY 0.9	2007 Deneus	N. B.	e, Print) Mayle				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🛴 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 11:18 P.M JoAnne Day May 1, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Upper Chesapeake Medical Center Bel Air Harford 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 □ M 2 🛛 F 59 Director 216-50-2634 March 25, 1948 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Maryland | Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 624 Country Club Road 21078 U.S.A. Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner. Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>Toll Collector</u> State of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edwin Anderson Minnie Germano 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank Day (Husband) 624 Country Club Road Havre de Grace, MD 21078 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Highview Memorial Gar.May 5, 2007 | Fallston, Maryland 22. Name and Address of Facility Schimunek Funeral Home of Bel Air 21. Signature of Funeral S-rvice Licensee Them 2 Inc. 610 W. MacPhail Rd. Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Myoagrol **Physician** ALCHOL /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Hospital or Attending Physician: After this To the moores after death.

To the Funeral Director: Af

ed by the a detached f

ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumafic event, the M. di al Examiner must be notified at

12

State

Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

30 Name and address of person who completed cause of death (Item Lynna Mulya yewaya 32 Registrar's Signature 31. Date filed (Month, Day, Year) MAY 0 9 2007

and manner stated.

23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of N	Marylar 		artment of Hortificate of L		nd Mental		ene g. No.	07	14930
	Physici	an	Decedent's Name (First, Middle, Las	t)					2. Date Mont	of Death	Day	Year	3. Time of Death
	/Media	al	Anthony M. DiPi						Ma	у	5,	2007	10:25P M
	Examir	er	4a. Facility Name (If not institution, give 510 Winslow Driv		ar)		4b. City, Town, or		Death		4c. Cou	unty of Death	
	Funeral		5. Social Security Number 6. Se		Age (In yrs.	last birthday)	If Under 1 Year	l Air	4 Hrs. 8. Date	of Birth		Harfo 9. Birth	
	Funeral Director			∑ M 2□F	72	Yrs.	Months Days	Hours	Min. (Moni	h, Dav, Y	^(ear) 1935	Cou	place (State or Foreign ntry) aryland
	pu ,		Usual Residence of Decedent		1.0								
	anyla shov	7	10a. State 10b. County		10c. Cr	ty, Town or Lo	cation						10d. Inside City Limits 1 ☐ Yes 2 X No
	the M	Directo	Maryland Harf 10e. Street and Number	ord			Bel Air			100	- 0::	of What Cou	
	with Sa or	io	510 Winslow Drive				21015			100		S. A.	iid y z
	death	Funerai	11. Marital Status	12. Was Decede			Was Decedent of His	spanic Orig	in? (Specify Yes	or No-		Race - Ameri	can Indian,
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other then "neturel", or Items 23a or 28e-1 show any injury or other treumatic event, Item Alcel Exaction to the frailing of Angles.	by	1 ☐ Never Married 2 🕱 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Force 1 X Yes 2 [If Yes, Give Year or Date:	□No	I	f Yes, specify Cubar	Specify:	Puèrto Rican, et	;.)		Black, White, Bc <i>ify:</i>	_{etc.} Vhite
2-0	72 ho	eted	15. Decedent's Ed (Specify only highest grad			16a. Deced	lent's Usual Occupa kind of work done di	tion	of working	16	3b. Kind o	f Business/Ir	ndustry
7	ithin ne.	Completed	Elementary/Secondary (0-12)	College (1-4c	or 5+)	life 1	20 NOT use retired) r member d	of the	_		_		States
7	iled w dygier her ti		12 17. Father's Name (First, Middle, Last)				of Delega	ates	's Name (First, M	V-1-11- 0.4-		overnm	ent
and	d be f antal h sed of	Be	Anthony M. DiPie	tro Sr				IO. MOUTH	Rose F			name)	
2	should bd Me mark matic	င္	19a. Informant's Name/Relationship (7			19b. Mailin	ng Address (Street a	nd Number				wn State Zii	o Codel
Z	nd 2 alth ar 27 is r treu		Mildred A. DiPiet)		Vinslow Di				-		
re,	s 1 a of Hea item othe		20a. Method of Disposition		20b. F		sition (Name of natory or other place		Date	-		on - City or T	own, State
Ĕ	Page nent c int: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☑ Other (Specify		re l				/09/2007	, ,	Cimon	ium. N	Maryland
alti	permit. Departn Importe any inju		21. Signature of Funeral Service Licen		sentre.						inera	11 Home	of Bel Air
<u> </u>	8258		Buin a. l	ull	~	Ir	nc., 610 V	V. Ma	cphail R	d.,	Bel A	Air, M	d. 21014
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only or	lications that caus ne cause on each	ed the deat line.	th. Do not enti	er the mode of dying	, such as c	ardiac or respirat	ory arres	t,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. COL	0 N	CANCE	K.						4.5 years
П	/Medical Examiner			Due to (or a	as a conseq	quence of):							3
	1	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. — Due to (or a	as a conseq	quence of):							
γħ.	uted d ansit	Examine	cause. Enter Underlying Cause Ciscose or injury that initiated events										
٧.	cate be executed physician and the burial-transit	Ex	resulting in death) Last	Due to (or a	as a conseq	quence of):							
8760,	ate b	dicai		d								4	
9	entific ding p	/Me	IF FEMALE:	22a If yes outcom	no of program	2004	-				-		***
.O. Box	The law requires that the death certificate be executed tto has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcon 1 □Live birth 4 □Pregnant 9 □ Unknown	2 Feta	aldeath 3□	Ectopic pregnancy Other (specify)			23d. Date of Month			ery Day Year
S, D	ires that signed b d be deta	by Pi	Part II. Other significant conditions co	ntributing to death	but not res	ulting in the ur	nderlying cause give	n in Part I.	23e.	Did toba	cco use c	ontribute to t	he cause of death?
rds	w require been sig should b								_	1 🗌 Yes	2 🗆 No	3 ☐ Prot	oably 4 Minknown
900	e law requ has been je 2 shouk	Completed								Was an autopsy	24	b. Were auto	psy findings available mpletion of cause of
Vital Record		Com							101	performe	d? I No	death?	2. No
/ita	Attending Physicien: The death. ector: After this certificate by the funeral director, pag	Be (25. Was case referred to medical examiner?						of Death (Check of		-		
	ys Si Gi	P	1 198 2 140			ER/Outpatien		4 14013	sing Home 5 🗷				ý)
Division of	or Attending Phater death. Director: After the in by the funeral	ion	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Ir (Month, L	njury Day Year)	28b. Time of Injury	28c. Injury Work	at ? es 2⊡N	28d. Desc	ribe how	injury occ	curred	
S	uttendi death. ctor: A y the fu	licat	2 Accident investigation 3 Suicide 6 Could not be	28e Place of I	lniury - At h	ome farm stre	eet, factory, office	92 Z [] [V		ion (Stree	et and Nu	mher or Rur	al Route Number,
<u>></u>	spitel or A ours after lerel Direc filled in by	Certification:	4 ☐ Homicide determined	building,	etc. (Specif	ý)	ot, lactory, office		City	r Town,	State)	mber or riare	ir route reamber,
	5 4 15 S	edical C	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the besiner: On the basis and manner	of examina	owledge, death ation and/or inv	occurred at the time restigation, in my opi	e, date and nion, death	place, and due to occurred at the	the causime, date	se(s) and and plac	manner as s ce, and due to	tated. the cause(s)
	To the P within 24 To the F complete	W	29b. Signature and title of certifier	10			29c. License	number		29d	. Date sig	ned (Month,	Day, Year)
			well the	· v			D ØØ 5	7802	•	N	IAY	07	2007
	U		30. Name and address of person who c	ompleted cause of	death (Item	n 23a) (Type, I	D ØØ S Broadwa	. A		. ^	1.	1 1	
	Sta	to	Wells Messersmith 31. Date filed (Month, Day, Year)	32. Fleais	TO (strar's Signa	Nor 15	Broadwa	is, B	altimer	, V.	15	im-d	21231
	Sta Registr		MAY 0 9 20	07		K A	ackles						
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of N 1 - State Amend Items 23a, PtI, I	laryland / Depa I,25 per Æ	artment of Health and CR67 05/09/07dh	Mental Hygiei b	ne No 2 0 0 7	14931
	0		Decedent's Name (First, Middle, Last)			2. Date of Death	3.	. Time of Death
	Physic /Medi		CHARLES HOWARD DIXON			FEB. 01	2007	6:32A ^M
	Examir	ner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Dea	ath	4c. County of Death	
	-	//	5708 GWYNN OAK AVENU 5. Social Security Number 6. Sex 7. A	E .ge (In yrs. last birthday)	BALTIMORE C		N/A	(State or Foreign
L	Funeral Director		213-92-3534 ¹ ⅓ ^{M 2□F}	4.4 Yrs.	Months Days Hours Mil		ar) Country)	
800	pu ,	6	Usual Residence of Decedent	10a Chu Taura aila		03/03/1		
	n the Marylan r 28a-f show notified at	ō	10a. State 10b. County N/A	10c. City, Town or Lo	MORE CITY		í	nside City Limits 1 ဩ Yes 2 ☐ No
	the N 28a-1 notifi	Director	10e. Street and Number	DABITI	10f. Zip Code	100	Citizen of What Country?	
	h with 23a or st be	al Di	5708 GWYNN OAK AVEN	UE	21207		USA	
	r deat	Funeral	11. Marital Status 12. Was Deceden Armed Forces	t Ever in U.S. 13.1	Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	(Specify Yes or No-	14. Race - American In Black, White, etc.	ndian,
36	s afte	by F.	1 Never Married 2 Married 1 Yes 2 If Yes, Give] No	1 ☐ Yes 2 【X No Specify:	sito riioan, etc.)	Specify: BLACI	Z
215-0036	72 hours after death with the Maryland "natural", or Items 23a or 28a-f show dical Examiner must be notified at		3 Widowed 4 Divorced Year or Dates 15. Decedent's Education		dent's Usual Occupation	16b	Kind of Business/Industr	
215	¥ a iii	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or	(Give life, L	kind of work done during most of w DO NOT use retired)	rorking	Time of Business/Industr	y
21		Con	10TH	LABO			ONSTRUCTIO	ON
and	be od o	Be	17. Father's Name (First, Middle, Last) JOHN C. DIXON			ame <i>(First, Middle, Maid</i> BURRIS	en Surname)	
Maryland	d 2 should by th and Menta 7 is marked traumatic ev	မ	19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street and Number or I		v or Town State 7in Con	(0)
	1 and 2 s Health ar em 27 is other trau		RONALD W BURRIS SR/BRO					
Baltimore,	ges 1 and t of Healt If item 2 or other		20a. Method of Disposition ★★★★ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Dispo-	sition (Name of natory or other place)		Location - City or Town,	
ţ	. Pages tment of I tant: If its jury or o		4 Donation 5 Other (Specify)	#		06/07 WI	NDSOR MILI	L, MD
Ball	permit. Pag Department Important: I any Injury o		21. Signature Tuneral Service Licensee	(/	Name and Address of Facility LIBERTY H	HOWELL FU	NERAL HOME	21207
			23a A. J. Enter the disease, or complications that cause	gwiz _	er the mode of dying, such as cardi		E, BALTIMO	oroximate
	Physician		snoc in heart failure. List only one cause on the Immune Cause (Final	all Mark	to the mode of dying, such as cardinated	ac or respiratory arrest,	Inite	erval Between set and Death
2	/Medical		disease or condition resulting in death) Due to (or a	s a consegn nce of):	10,00		,	111
4	Examiner		Sequentially list conditions bb.	n Imal	le Cell L	ma C	oncer -	
	led sit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	s a consequence of):			4.5	
,	ficate be executed physician and s the burial-transit	Examin		s a consequence of):		143	10 110	
8760,	te be o	dical				/ WICHLY	EXAMINER	
Θ	rtifica ng ph	Medi	IF FEMALE:			A BROVED BY MEDIA		
Вох	death certifi e attending d for use as	lan/	23b. Was decedent pregnant in the past 12 months?	e pf pregnancy 2 □ Fetal death 3 □	Ectopic pregnancy	West.	23d. Date of delivery	Vana
0	that the death certified by the attending detached for use as	Physician/Me	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant a 9 ☐ Unknown 9 ☐ Unknown	at time of death 5	DEctopic pregnancy Other (specify)		Month Day	Year
Δ.	The law requires that the site has been signed by the page 2 should be detache	y Ph	Part II Other significant conditions contributing to death				o use contribute to the ca	use of death?
Division or Vital Records,	w requires that been signed to should be deta	ed by	Meherron	for Jun	I A hot Won	1)X Yes	2 No 3 Probably	4 ☐Unknown
eco	has bee	plet	Alexantin Co			24a. Was an	24b. Were autopsy f	indings available
<u>~</u>		Completed	1 Janus Hace	410		autopsy performed? 1 Yes 2 1 1	prior to complet death? √o 1 ☐ Yes 2 ☐	
Vita	ician sertifi ector	Be	25. Was case referred to medical examiner?			eath (Check only one)		
ō	g :s: ×	<u>۲</u>	27. Manner of Death 28a. Date of Inj			Home 5 ☐ Residence	6 Other (Specify)	ospice
ion	Attending or death. ector: Afte by the fune	tion	1 XNatural 5 ☐ Pending (Month, Da 2 ☐ Accident investigation		28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	25d. Describe now in	ary occurred	
Nis	r Atte er des rector by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 28e. Place of in	jury - At home, farm, stre tc. (Specify)	eet, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Rou	ite Number,
	ital o					1		
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier (Cherk only one on the basis	of examination and/or inv	occurred at the time, date and place vestigation, in my opinion, death occ	ce, and due to the cause curred at the time, date a	(s) and manner as stated. Ind place, and due to the	cause(s)
	Vithin Vithin Comple	Mec	29b. Signature and filly of codifier	ated.	29c. License number	29d. E	Pate signed (Month, Day,	Year)
			Khillh Haus	M Acc.	PROFT 48/60	02	105120	97
			30 Name and address of parson who samplesed cause of		Print GREENS (REET RI	LTINORE 2	21201 /1D
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	Sta Registra	te ar	31. Date filed (Month, Day, Year) MAY 0 9 2007	rar's Signature	•			
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 10:20 A M Roland Frederick Day May 6, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Stella Maris Timonium Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) Funeral 1**X** M 2□ F Months Days Hours Min Director 228-42-0913 18, 1933 Virginia Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show 1 ☐ Yes 2X No Item 27 is marked other than "natural", or items 23a or 28a-f st other traumatic event, the Medical Examiner must be notified Director Maryland Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 703 Mallard Ct. 21040 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: African American 1 ☐ Yes 2X No δ Specify. 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any injury or other traumatic exercises. College (1-4or 5+) U.S. Army Chaplain 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter A. Dav 2 Annie Whartman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dolores J. Day (Wife) 703 Mallard Ct. Edgewood, MD 21040 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory May 9, 2007 Baltimore, Maryland 22. Name and Address of Facility Schimunek Funeral Home of Bel Air 21. Signature of Funeral Service Licensee M Inc. 610 W. MacPhail Rd. Bel Air MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) DEMENTIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): physician Physician/Medical the attending | for use as 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 2 🗆 No the 9□Unknown 9 Unknown ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ The law requires 1 ☐ Yes 2 ☐ No 3 Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has page 2 s autopsy certificate 1□ Yes 2 X No. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2X No 1 ☐ Yes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 2

Box 68760, o م

Baltimore, Maryland 21215-0036

2007

Division or Vital Records, ROLAND DAY this After To the Hospital or Attending nours after death.

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filled in by the fu death.

Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{X} \) Other (Specify) \(\text{HOSPICE} \) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 Pending investigation 1 🗶 Natural Injury 1 Yes 2 □ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

one)			and manner stated.
29b. Signature and	itle of certifier)	
•		/-	_

29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD.

State Registrar

5

within 24 hours To the Funeral

State of Maryland / Department of Health and Mental Hygiene UU 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** DIXON 6:30A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3209 Batavia Avenue Baltimore Baltimore City If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 06/07/1955 Funeral 6 Sax 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Months Hours 1**№** M 2□ F 301-54-5650 Yrs. FLDirector Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location 28a-f show other traumatic event, the Medical Examiner must be notified at 12 Yes 2 No Director Baltimore City Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3209 Batavia Avenue 21214 USA or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Det es 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after of Hygiene. "haturel", or Item then "naturel", or Item 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Ď Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Commercial College (1-4or 5+) Elementary/Secondary (0-12) Diver Pages 1 and 2 should be filed vinent of Health and Mental Hygie ant: If Item 27 Ie marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Allen Dixon Washington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dedric T. Dixon/Son Department of Health a Important: If Item 27 Is eny Injury or other training once. 5239 S. Saratoga Youngstown, OH 44515 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State May 8 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Beltsville, Maryland Chesapeake Crematory Inc. 2007 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee M01443 22 Name and Address of Facility Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, Maryland 21286-23a. Part 1. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** to van cee /Medical Due to (or as a consequence of) Examiner Sa uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical the th use as IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown 2 signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2X No certificate Division of Vital 1 Yes 1 ☐ Yes 2 ☐ No After this certific funeral director. 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of eath 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending within 24 hours after death. To the Funeral Director: A investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) ふて Completed cause of death (Item 23a) (Type, Print) arrison MD 3900 Loch Raven Blvd. Boltim rend 21218 Name and address of person who harles M. Harrison MD 31. Date filed (Month, Day, Year)

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Registrar

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	Funeral		Social Security Number 6. Se	, , ,	s. last birthday)	If Under 1 Year Months Days	If Under 24 Ars. Hours Min.	8. Date of Birth (Month, Day, Y	9. Birth	nplace (State or Foreign
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/lar	should be filed nd Mental Hygi marked other umatic event, 1	To	Charles Leonard	Sills			Nellie	(unk) Bo	yd	
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و			1 ☐ Burial 2 🔀 Cremation 3 ☐ F	Removal from State	cemetery, crer	natory or other plac	θ)		c. Location - City or 1	
Baltimore,	permit. Page Department o Important: if eny injury or once.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens		, T.	Service (-		wson, Mar	yıana
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	To the Hospital or within 24 hours efter To the Funerel Directory of th	Mec	29b. Signature and title of certifier	and manner stated.		29c. License	number	29d.	Date signed (Month	, Day, Year)
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	di		30. Name and address of person who or	ompleted cause of death (Ite	em 23a) (Type,	Print)	, 1 / 3	1 0	1 7/0/	
_	10		MANN /	nccine in	N 6	J Mai	Phan/ M	1 rel	An M	1 2/0/4
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mabel Davis

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** MARY FRANCES DAIGLE 2007 MAY 9:20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CARROLL HOSPITAL CENTER WESTMINSTER CARROLL If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 💢 F 213-30-6347 Yrs. 72 Director 10/4/1934 NORTH CAROLINA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at MD CARROLL WESTMINSTER 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2542 MURKLE RD. 21158 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 2 should be filled within 72 hours after n and Mental Hygiene. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💆 No Specify: Specify: WHITE ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ELECTRICAL Elementary/Secondary (0-12) College (1-4or 5+) OFFICE MANAGER CONTRACTOR 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ ADAM SAFRIT JOHNNIE WATTS ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is rr any injury or other traum once. THEODORE J. DAIGLE-HUSBAND 2542 MURKLE RD., WESTMINSTER, MD 21158 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) JOSEPH CEMETERY 5/8/2007 TANEYTOWN. uneral Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD 23a. Part1. There the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) that the death certificate be executed burial-transi attending physician and Due to (or as a consequence of): Box 68760, Physician/Medical the use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 No
9 ☐ Unknown Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) Records, P.O. 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Orabeles NONIMOUN dependent Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 2 No Division or Vital 1□ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 2ER/Outpatient 3 DOA မ 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: To the Hospital or Attending Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Kanco K GOLUW IL MO 031660 500)

Registrar

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31. Date filed (Month, Day, Year)

K-GALVINI III MO 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

STONER AVENCE

WESTMINSTER MALYIAND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** May 2007 9:25P M Hilda Dency /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rose Manor Assisted Living Ellicott City Howard 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 1 x 1 F 220-07-1143 Director 94 Dec.24, 1912 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐Yes 2 No Director Maryland Howard Ellicott City 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA
4. Race - American Indian, 10213 Cabery Road 21042 Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 1 Never Married 2 Married 'natural", or Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🗷 No ģ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bank Teller Banking Department of Health and Mental Hygic Important: If item 27 is marked other I any Injury or other traumatic event, the once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henry C. Birx Ella Shelhaus ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Michael B. Dency 10213 Cabery Road; Ellicott City, MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lawn Mem. Garden 5/9/2007 Marriottsville. Maryland 22 Name and Address of Facility Sterling Ashton Schwab Witzke Crest 21. Signature of Funeral Service License Funeral Home of Catonsville, Inc. Tanda 630 Edmondson Avenue; Catonsville, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ADVANCED disease or condition resulting in death) DEMENTIA 44123 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, 承 Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autops, performed? 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be ASSISTED FIVING Other: 4 Nursing Home 5 Residence 6 Cother (Sp Hospital: 1 ☐ Yes 2 N 1 Inpatient 2 ER/Outpatient 3 DOA ۵ 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No Director; 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and t 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

30. Name and

31. Date filed (Month, Day, Year)

10700 CHAME

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erson who completed cause of death (Item 23a) (Type, Print)

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egistrar's Signatur

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JUNA ARTAN

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Records,
of Vital
Division

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21215-0020 d within 72 hours after death with the Maryland glene. w than "nature!", or items 23a or 28a-f show if the Madical Examiner must be notified at	þ	1 Never Marrie		Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates	No	If Yes, specify Cu		to Rican, etc.)	Specify	k, White, etc. * Asian
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Baltimo pemit. Page: Department of Important: If I any Injury or	1	21 Signature of Fur	neral Service Licer	Stur V	U	22. Name and Ad March F/ 4300 Wab	H West	Balti	more,	Md 21215
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Division of Vital Records, P.O. Box 687 or Attending Physician: The law requires that the death certificate efter death. Director: After this certificate has been signed by the attending phys of the funeral director, page 2 should be detected for use as the	Completed by Physician/M							24a. Was a perfor		24b. Were autopsy findings available prior to completion of cause of death?
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Afte Afte octo	13	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of In	jury - At home, fa	rm, street, factory, office	9	28f. Location (S. City or Town		er or Rural Route Number,
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Division of Vital Rewithing the Hospital or Attending Physician: The law within 24 hours effer death. To the Funerel Director: Affer this certificate has completely filled in by the funerel director, page 2	edicai	29a. Certifier (Check only one)	1 Certifying Ph 2 Medical Exam	ysician: To the best niner: On the basis of and manner s	of examination an	, death occurred at the d/or investigation, in my	time, date end place opinion, death occu	, and due to the corred at the time, d	euse(s) and ma late and place, a	nner es steted. and due to the cause(s)
Withii To th	2	29b. Signature and t	title of certifier				nse number		9d. Date signed	d (Month, Day, Year)
		- OKOT	he Sui	en, D:	0.	Ke	25-000)	May	7,2007
1		30. Name and addre	ess of person who	completed cause of	death (Item 23e)	Type, Print)				
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	ate	31. Date filed (Month	h, Day, Year)	32. Pegist	rar's Signature	Sperter Sperter		-		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #28d, perFH, C867, 5/9/07 TT
State of Maryland / Department of Health and Mental Hygiene

1. For State Amend #1,PI,25,27,28a-f, perME, g867, 5/9/07 TT
Registrar

Reg. No. 2. 1 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 19.57 FAYALL, JA. 2007 ALONZO Apr /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Ba Baltimore (11)
If Under 1 Year | If Under 24 Hrs. Hopkins Johns Hospita NA 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 □ F Months Days Hours Min 215-72-0278 Yrs. Director June 6,1958 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 1 Yes 2 No Director Baltimone 10g. Citizen of What Country? 10e. Street and Number 21213 3165 Funeral 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 No 1 Never Married 2 Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify: APRI Can Specify: Baltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced "natural"; Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) the Me Elementary/Secondary (0-12) College (1-4or 5+) OF Balth Laborer 104 7 is marked other traumatic event, 1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be W. Fayall, Dornel Gretnide 2 Alonzo 19a. Informant's Name/Relationship (Type. Pant) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other trau Bultimore MD ZYZ13 Gretnoe Fayall mother 3165 Lyndale Avenue 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State Brywien Grematon 4 □ Donation 5 □ Other (Specify) 21. Signature of Hun ral Sen ce Liv Close Funera Belain Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death PSEUDOMONAS Immediate Cause (Final PNEUMONIA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner QUADRAPLECIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Que to (or as a consequence of) Examiner CERTIFICATION DOROVED BY MEDICAL EXAMINER Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) by the a 9☐Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown ANOXIC BRAIN INJURY Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has be lirector, page 2 s autopsy performed? 1 ☐ Yes 2 ☑ No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2⊠ No ဥ funeral 28b, Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Diving Driving Accident 1 ☐ Yes 2 No Summer, 1976 unk. 2 Accident i Director: d in by the f 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide after hin 24 hours aft the Funeral Di mpletely filled ir Cove Rocky Point Park, Middle River, MD 152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2. 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) RES-000 APRIL 12, 2007 MEDICAL RESIDENT 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 NORTH WOLFE STREET, BACTIMORE, MARYLAND 2487 TEDFORD, M.D. 31. Date filed (Month, Day, Year) State 04 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month <u>4:1</u>6a ^M MAY 5, 2007 JAMES HENRY FORBES, SR. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A 4806 ALHAMBRA AVE. BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1♥M 2□F Director NORTH CAROLINA 3-28-1931 213-30-4541 76 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at N/A BALTIMORE 1X Yes 2 No Directo MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4806 ALHAMBRA AVE. Funeral 21212 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 √Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) POSTAL WORKER FEDERAL GOVERNMENT and Mental Hygies marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and 2 should be Ith and Menta 27 Is marked traumatic e JAMES WILSON RUBY FORBES 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 Is any injury or other trau once. ANNA V. FORBES (WIFE) 4806 ALHAMBRA AVE. BALTIMORE, MARYLAND 21212 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) /3 □Removal from State GARRISON FOREST VETERANS OWINGS MILSS, MARYLAND 21. Signature of Funeral Service Ucenseg ONATH AN HIBN R22. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part1. Er er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or huart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Caus (Final disease or candition resulting in death) CELL SMALL LUNG CANCER **Physician** 2 mo /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it are cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of Examine The law requires that the death certificate be executed and the burial-tran resulting in death) Last Due to (or as a consequence of) Box 68760, physiclan Physician/Medical as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death Month Day Year 5 Other (specify) Division or Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No this certificate has all director, page 2 : autopsy performe 1□ Yes 2 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only ope) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \sum Nursing Home 2 No 1 Tyes Certification: To 5 Residence 6 ☐Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manne Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 atural Injury death. 1 ☐ Yes 2 ☐ No or Attendate death.

Director: / 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 🗌 Homicide To the Hospital within 24 hours a To the Funeral I 1 critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year)

State

DHMH 17 Rev 1/2001

Registrar

RISTINA

31. Date filed (Month, Day, Year)

SINAI HOSP

2401 W BELVESERE AVE BALT, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. egistrar's Signature

TRUICA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1 per doc 9867 5-9-07 vt. State of Maryland? Department of Health and Mental Hygiene Certificate of Death Reg. No. C. 2. Date of Death 1. Decedent's Name (First, Midgle, Last) Lyda **Fowler** Month Dav Year **Physician** 220VM 02 07 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 8035 Woodholme Circle Anne Arundel Pasadena If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 205 F Months Hours Min. North Carolina May 01,1935 72 242-46-0851 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Pasadena Director Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21122 U.S.A. 8035 Woodholme Circle by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married White Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Geico Insurance Claims Adjuster 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elue Nichols Mina Daniels ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a important: If item 27 is any Injury or other tra 8035 Woodholme Circle, Pasadena, Maryland 21122 Patricia A. Earp (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Glen Haven Mem Park 05-05-07 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122 Art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ate has been signed by the atte page 2 should be detached for Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions/contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 🗶 No 24a. Was an autopsy S certificate 1∐ Yes fo the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 ☐ Yes 250 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) Certification: To After this 27, Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 🗌 Yes 2 No death. Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29c. License number 29d. Date signed (Month, Day, Year) Chief Medical Officer 3 Hospice of the Chesapeake D 21438 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael J. LaPenta, M.D., 445 Defense Highway, Annapolis, MD 21401 31. Date filed (Month; Day, Year) 32. Restrar's Signature State

Registrar

MAY 0.9 2007

			1 - For State Registrar		Maryland / Dep <i>Ce</i>	artment of ertificate of			iene 007	14941
	Physici /Medi		Decedent's Name (First, Middle, La Mary Louise G	•				2. Date of Death	$\begin{array}{ccc} & & & & & & & & & \\ & & & & & & & & & \\ & & & & $	A 12.7. 7111
7	Examir	ner	4a. Facility Name (If not institution, giv		er)	4b. City, Town,	or Location of Dea	ath /	4c. County of De	ath
	<u> </u>		Loch Raven Ce 5. Social Security Number 6. 5		Age (In yrs. last birthday		ltimore	S. 8. Date of Birth	100	interior (Otto F
- 63	Funeral Director			_M 2∏F	90 Yrs.	Months Days			Year) 9. B	irthplace (State or Foreign Country) Maryland
			Usual Residence of Decedent		70			July 11	, 1910	Maryianu
)	r 28a-f ahow	_	10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
•	the Ma 28a-f a	Director		timore		Balt	imore			1 ☐ Yes 2X No
ر	death with the Maryland ms 23a or 28a-f ahow must be nutified at		10e. Street and Number			10f. Zip Code		10	g. Citizen of What (·
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36	within 72 hours after d ene. then "naturel", or item he Medical Examiner.	by Funerai	1 Never Married 2 Married	Armed Force 1 Tes 2 If Yes, Give	es? M∑No	1 Yes 2 No		Specify Yes or No- irto Rican, etc.)	14. Race - An Black, Wh Specify:	
9	hour turel	pa pa	3 Widowed 4 □ Divorced 15. Decedent's E	Year or Date		edent's Usual Occu	ti		W	hite
5	in 72 n "na	Completed	(Specify only highest gra	ide completed)	(Giv.	e kind of work done DO NOT use retin	ipation e during most of wi ed)	orking	l6b. Kind of Busines	s/Industry
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b	al Hyg	Be C	17. Father's Name (First, Middle, Last,	1				ame (First, Middle, M		
<u>Ja</u>	Menta	10	John Herbert L	amm			Ma	ry Louise	Long	
Maryland 21215-0936	s 1 and 2 should be filed v if Health and Mental Hygie Item 27 is marked other t other traumatic event, in		19a. Informant's Name/Relationship (Type, Print)	19b. Mail	ing Address (Stree	t and Number or F	Ru <i>ral R</i> oute Number,	City or Town, State,	, Zip Code)
	and fealth m 27	U	Shirley Lanehard	lt (Daugh			ld Manor	Dr., Balt		
0	it of H	1 1	20a. Method of Disposition 1	Removal from Sta	20b. Place of Disp cemetery, cre	osition (Name of matory or other pla	100)	Date 2	Oc. Location - City of	or Town, State
Baltimore,	t. Pa ntmen ntant: njury	ı	4 Donation 5 Other (Specification)			d Cemeter		04/2007	Baltimore	, Maryland
Bal	permit. Pages 1 Department of H Important: If Ite eny Injury or ot		21. Signature of Funeral Service Licer	elle	^	9705 Bela	ir Road,	himunek F Baltimor	e, Maryla	mes nd 21236
	Physician	i i	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that causone cause on each	n line.	ter the mode of dy		ac or respiratory arre	st,	Approximate Interval Between Onset and Death
	/Medical Examiner			b	as a contrequence of):					
. 8	cuted od ransit	Examiner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or	ತಿತಿ ತೆ ಕರಣಕಿಲ್ಗಳು ಚೀರಿಕ of j:					
8760,5	cate be executed bhysicien and the burial-transit	dical Ex	resulting in death) Last	Due to (or	as a consequence of):					
9	certificate nding phys use as the	Medi	15 -5.1.1.5							
B.	death e atter	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		2 ⊟Fetal déath 3í tat time of death 5í	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of de Month	elivery Day Year
<u>α</u>	s that the ned by th e detache	y Ph	Part II. Other significant conditions	ontributing to death	but not resulting in the u	inderlying cause gr	ven in Part I.	23e. Did toba	acco use contribute	to the cause of death?
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သွ	lawre as bec	plet						24a. Was an	24b. Were a	autopsy findings available
Ě	The law ete has b page 2 st	E						autopsy perform 1 Yes 2	ed? prior to death? ☑No 1 ☐ Ye	
ita.	sien: artific ctor.	Be	25. Was case referred to medical examiner?		700-11-		26. Place of De	ath Check only one		3 24 110
<u>}</u>	Physicien: this certifice ral director, I	2	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpa		nt 3 DOA	her: 4 Nursing	Home 5 ☐ Residen	ce 6 Other (Sp.	ecify)
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Division	Attending ir death. ector: After by the fune	icat	2 Accident Investigation 3 Suicide 6 Could not be		Injury - At home, farm, st]Yes 2 □No	206 Lanatina (Cau		
Div.	al or A efter Direction of in by	Certification:	4 Homicide determined	building,	etc. (Specify)	reet, factory, office		City or Town,	eet and Number or F State)	Hurai Houte Number,
	To the Hospital or Attending Physicien: The law within 24 Hours elier death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	edical C	29a. Certifier (Check only one)	ysician: To the be liner: On the basis and manner	st of my knowledge, deat s of examination and/or in	h occurred at the ti vestigation, in my	me, date and plac opinion, death occ	e, and due to the cau urred at the time, dat	ise(s) and manner a e and place, and du	s stated. e to the cause(s)
	vithin o the		29b. Signature and title of certifier	and manner	7 21	29c. Licens			d. Date signed (Mon	
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	6		X/AUZHOU	6701	f death (Item 3a) (Type,	Print) (0 s	st.	4202	Bulti	200% ime 2/204
36,	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 9 201	32 Regis	strar's Signature	de				

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2007 Year Physician Month 04 Steven Merrill Gero 23 04:26a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1X M 2 □ F 56 213-54-5252 Director 08-02-1950 CA Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director MD Montgomery Silver Spring 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3903 Gannon Rd. 20902 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No 1970 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2K No þ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Retail 12 Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Earle C. Gero Lois Ramsey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tina M. Gero/daughter 3903 Gannon Rd. Silver Spring MD 20902 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 04-23-2007 Bethesda, MD 45 Donation 5 ☐ Other (Specify) USHUS 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rapp Funeral & Cremation Service 22. Name and Address of Facility Rapp Funeral 933 Gist Ave Silver Spring 23a. Partl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MO0382 933 Gist Ave Silver Spring MD 20910 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Atherosclerotic Cardiovascular Disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to improve Due to for as a consequence of if any leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Exami and Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Chronic Obstructive Pulmonary Disease Completed 1 ☐ Yes 2 ☐ No 3€Probably 4 ☐Unknown Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) L_o 1 ☐ Yes 2 ☒ No 2 ER/Outpatient 3 DOA 1 Nnpatient this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury I Director: / 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760,

hin 24 hours at the Funeral D mpletely filled i within 2

State

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Medical

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

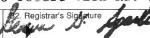
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 0043539

29d. Date signed (Month, Day, Year)

30. Name and across of person who completed cause of death (Item 23a) (Type, Print)

Raymond White 1500 Forest Glen Rd. Silver Spring MD 20910

31. Date filed (Month, Day, Year) MAY 0 9 2007



Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** SERNARDINO /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arunde1 5. Social Security Number Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Sex M 2□F **Funeral** Months Days Hours Min Director 86 Dec 29, 1920 159-16-1195 Pennsylvania Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show at 7 is marked other than "natural" or items 23a or 28a-f st traumatic event, the Medical Examiner must be notified 1 XYes 2 No Director Maryland Anne Arundel 0denton death with the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1108 Colony Ridge Road 21113 United States Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. l be filed within 72 hours after and Hygiene. 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: þ Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th Federal Government College (1-4or 5+) Civil Service & Military 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental h Pietro Guerrieri Puritana Grossi 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Kathe M. Guerrieri/wife 1108 Colony Ridge Road Odenton, Maryland 21113 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State Department of himportant: If ite any Injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) W. Arundel Crematory 5/10/2007 Odenton, Maryland 21. Sign re of Funeral Service 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. Apomos " Manita 1411 Annapolis Road Odenton, Maryland 21113 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ANGLIA disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) The law requires that the death certificate be executed physician and s the burial-tran resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) o. 9 Unknown 9 Unknown Records, P. Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has death? certificate 1∏ Yes Division or Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 📉 No Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation neral Director: / 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated. ro the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

Name and address of person who

			-	For State Registrar	State of	f Maryland		artment <i>tificate</i>			and M	lental Hy	giene Reg. No./	2007	7	14945
				Decedent's Name (First, Middle, La	rst)							2. Date of De	ath Day	Year		3. Time of Death
		Physicia /Medic		Rosalie E.	Grant							May	7,	2007		11:35p M
		Examin		4a. Fecility Name (If not institution, gir		n <i>ber)</i>	Jak.			Location of	of Death			County of De		
				Stella Maris				If Under		nium If Under	24 Hre	O Data of Bi		altimo		- (State of English
		Funeral			Sex 1□M 2₩F	7. Age (In yrs. I 93	ast birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da MAR 31	rn ay, Year) 101	/ Mai	Pountry	ce (State or Foreign
		Director	-	Usual Residence of Decedent	Λ	93		l				TIMK JI	, 171	4 [110]	утс	1110
		land low		10a. State 10b. County		10c. City	, Town or Lo	cation							10 d	. Inside City Limits
		Man	į	Maryland Baltimo	ore		Ti	moniu	m							1 □ Yes 2 □ No
		th the	Funeral Director	10e. Sfreet and Number				10f. Zip	Code				,	en of Whaf (Country	1?
		23a	ai	2300 Dulaney Val						21093				USA		1. 1.
		er des	nue	11. Maritaf Status	Armed Fo	edent Ever in U.	S. 13.	Was Deced ff Yes, spec	ent of Hi ify Cuba	spanic Ori n, Mexicar	gin? (Sp n, Puerto	ecify Yes or No Rican, etc.)	0- 1	 Race - An Bfack, Wh 		
	36	s afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □Yes If Yes, Giv Year or D	2M_No /e ates:		1 ☐ Yes 2	₹No	Specify:				Specify: \	√hit	te
	응	filed within 72 hours after death with the Maryland Hygiene. Ithy than 'natural', or items 23a or 28a-f ehow ent, the Madical Examinar must be untitled at	edit	15. Decedent's E	ducation		16a. Dece	dent's Usua	l Occupa	ation			16b. Kin	d of Busines	s/Indu	stry
	15	nin 72	Completed	(Specify only highest gi	rade completed) Colfege (1	I-40r 5+)	life.	kind of wor DO NOT us	e retired)	t of work	ing				
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	멀	al Hy d oth	Be (17. Father's Name (First, Middle, Las	•							e (First, Middle		Surname)		
M	yla	Ment Ment arka atic	ဥ	Nathan E. Ha								lred Hu		T 01	7: 0	
Ъ	Na.	2 sh and 1 sm		19a. Informant's Name/Relationship								al Route Numb				ode)
:35	e,	1 and Heelth em 27 ther t		Jackie R. Grant/o	laughter	20h P	lace of Disno	sition (Nam	ne of	1	#307	Date	20c. Loc	ation - City	or Tow	n, State
: 7]	Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Heelih and Mental Hygiene. Depertment of Heelih and Mental Hygiene. Depertment of Heelih and Mental Hygiene. Depertment of Heelih and Mental Hygiene. Depertment of Hygiene 21 is marked other than "natural" or items 23a or 28a-1 show any injury or other traumatic event, the Madical Examinat must be incutified at one.		1 X Burial 2 ☐ Cremation 3		State Kric	emetery, creder S	Cemet	her plac er y	Θ)	5/11/	2007	Wes	tminst	ter,	, MD
1	틒	ortme ortani injury		4 □Donation 5 □ Other (Spec 21. Signature of Funeral Service Lice		Λ	2:	2. Name an	d Addres	ss of Facili	ity					
	Ba	Depermination of the services once		Dayat ma	Monale	(H	aight O R	Fun	eral	Home	e & Cha	pel, MD 21	P.A. 784 (4	410 -	-795–1400)
				23a. Part1. Enter the disease, or con	nplications that of	caused the deat								104 (A	Approximate Interval Between
		Physician		shock, or heart failure. List onf Immediate Cause (Finaf		ronic	Oh	stru	ch.	ie t	'nΙυ	onam	Du	seuse	(Months
		/Medical		disease or condition resulfing in death)	a	(or as a conseq				- '					-	11011(1)
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		D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a conseq	uence of):									
		ate be executed hysicien and the burial-transit	Examiner	that initiated events resulfing in death) Last	c. Due to	(or as a conseq	uence of):								+	
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	687	ficate phys s the		">	a											
7	Вох	nding use a	N/M	IF FEMALE: 23b. Was decedent pregnant		tcome of pregna		∃Eatopis as	0000000				2	3d. Date of		
200		law requires thet the death certifica es been signed by the attending ph 2 should be delached for use as the	Physician/Med	in the past 12 months?		ointh 2 ☐ Feta nant at time of d		⊒Ectopic pr ⊒ Other (sp						Month	D	ay Year
	P.0	at the by th	hys	9 Unknown								an Did	4-1			and death?
7	-	es the igned be de	by	Part If. Other significant conditions	11		1				1.					cause of death?
MAY	ord	w requir been si should	sted	- 1 exipheral	VUS	cular	- D1	Sea	72					,		
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NT	a E	n: The icate he										1 ☐ Yes	210 No	1 U Y	es 2	No No
GRANT	of Vital	Attending Physician: r death. sctor: After this certifica	Be C	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospitaf:	Inpatient 2	EB/Outpatie	nt 3□ DC	Oth	or		th <i>(Check only</i> ome 5 □ Re:			necify)	
	of	Phy er this eral d	2.	27. Manner of Death		of Injury ofth, Day Year)	28b. Time (8c. Injur Wor		J. 51.19	28d. Describe			podity	
ITI	<u>.</u>	nding ath. r: Afte e fun	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigat		in, Day (Gai)	fnitury	М		Yes 2□]No					
ROSALIE	Division	ar des	Certification:	3 ☐ Suicide 6 ☐ Could not determine	286. Place	e of Injury - At h	ome, farm, si	reet, factor	, office				(Street and		Rural	Route Number,
K	Ճ	itei or irs afte rai Dir led in														
		To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate hes completely illed in by the funeral director, page 2	Medical	(Check only 2 Medical Ex	Physician: To the aminer: On the b	pasis of examina	owledge, dea ation and/or i	th occurred nvestigation	at the tir , in my c	me, date a pinion, de	nd place ath occu	, and due to the rred at the time	e cause(s) e, date and	and manner place, and o	as sta due to t	ted. the cause(s)
		the Implet	Med	one) 29b. Signature and title of certifier	and mar	nner stated.		290	. Licens	e number			29d. Dat	e signed (Mo	onth, D	ay, Year)
		To Your		A mosting	UNI	halt	MI		NS	52	74	0	M	ay 9	2 K	FOOS 4
		K		30. Name and address of person wh	o completed cau	ise of death (fter	m 23a) (Type	, Print)			, (<u>ں</u>	
		i)		FDNFCMINE MDT	сит м т	2300	ז ב. דוזת (VEV VZ	LLE	Y ROA	D T	'IMONIU	M, MD	21093	}	
	S. C.	Sta	ate	31. Date filed (Month, Day, Year) MAY 0 9 2	37.1	Registrar's Sign	ature An	ules								
		Regist	rar	MAY 0 9 2	007	الم معلق	19									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** May Richard Charles Grauer 2007 /Medical 8:30 A 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Gilchrist Center @ GBMC
5. Social Security Number 6. Sex Baltimore TOWSON
If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 MM 2 □ F Director 213-32-0133 22, 1932 Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ir than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Abingdon Maryland Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? , or Items 23a 21009 USA 1313 Harford Town Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 May Yes 2 No If Yes, Give Year or Dates: ↓ 1 ☐ Never Married 2 Married 21215-0036 1 ☐ Yes 2 ☑ No Specify. ģ 3 Widowed 4 Divorced White Korea Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Supervisor/Repair & Install Telephone Injury or other traumatic event, and 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental and 2 should be Augusta Matilda Kahler George Albert Grauer ဂ Maryl 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health ar
Important: If Item 27 Is
any Injury or other trau 1313 Harford Town Drive, Abingdon, Maryland 21009 Denise A. Grauer / Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Hilltop Service Corp. 5-10-07 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland 21. Signature of Funeral Service Licensee Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complication. That caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) THELLOMA MESO 2 years **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Due to (or as a consequence of): 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) Division or Vital Records, P.O. 9 Unknown 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Melanoma, nultiple 4 Unknown 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence MOther (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 28a. Date of Injury (Month, Day Year) Manner of Death

Natural

Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No Director: filled in by the 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 200

State

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Denace R FadknernD/555 W. Towsonton Blud/Balto MD 32 Registrar's Signature

Registrar

State of Maryland / Department of Health and Mental Hygien® 14947 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) MAY 7, 2007 **Physician** 5:00 a GREENSTREET HELEN /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner NZA 1409 CHERRY STREET BALTIMORE B. Date of Birth (Month, Day, Year)
AUG. 14,1920 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 XF Yrs. MARYLAND 218-07-9427 86 Director Usual Residence of Decedent 10d. Inside City Limits r 28e-f ehow 10a. State 10b. County 10c. City. Town or Location X Yes 2 □ No N/A BALTIMORE MD. Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code r then "naturel", or items 23a or tre Madical Examiner must be a 1409 CHERRY STREET 21226 U.S.A. death Funerai 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 Specify: þ WHITE 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE DOMESTIC 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) nd 2 should be fi th and Mental H 27 is marked of r treumatic ever ALEXANDER BALONIS JOSEPHINE GROCKI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOHN GREENSTREET/ SON 1409 CHERRY STREET, BALTIMORE, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition M Burial 2 Cremation 3 Removal from State permit. Peg Department Important: I any injury o HOLY CROSS CEMETERY 5/10/07 BALTIMORE, MARYLAND 4 Donation 5 Other (Specify) LILLY AGOSTERNER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTIMORE, MD. 21. Signature of Funeral Service Licenses 21231 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HYPERTENSIVA ARDIO VASCULAR **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ettending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) ed by the e 9 Unknown 9 Unknown signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown should I Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No certificete 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ဥ 28a. Date of Injury (Month, Day Year) After this 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation after death Director: / d in by the f 2 Accident 3 Suicide 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitei o within 24 hours aft To the Funerel Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ical 29a. Certifier 29b. Signature and title of certifier D17743 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001.5. HANOVER SI-, Swite 108, BALTIMORE, MD, 21225 L, SEENIVASAN, MD 32. Egistrar's Signature 31. Date filed (Month, Day, Year) State MAY 0 9 2007 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No./ 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 3, 2007 Wilbur 12:25 p ^M Harry May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Hospital Center Westminster Carroll If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) April 26, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F Months Yrs Director 85 1922 220-05-1699 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10a State 10c. City, Town or Location 10h. County 10d. Inside City Limits 1 ☐ Yes 2X No Director MD Carrol1 Hampstead 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code must be 3800 2A Sunnyfield Funeral Court 21074 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status other traumatic event, the Medical Examiner 1 Yes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: 3 X Widowed 4 ☐ Divorced Year or Dates: White WWII Completed | 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8th Lieutenant Balto Co. Fire Dept. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles O. Harry Rachae1 Watkins ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas R. Harry 111 Lamport Road 21136 Reisterstown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If It any Injury or o 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Park 5/7/07 Elkridge, Maryland 22. Name and Address of Facility Signature of Funeral Service Licenses 11824 Reisterstown Road ELINE FUNERAL HOME Reisterstown, MD 21136 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** nel monia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of): physician by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 1☐ Yes 2 To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ NO ² 1 Impatient 2 ER/Outpatient 3 DOA Director: After the 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 □ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d, Date signed (Month, Day, Year) -0054218 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Malcalm dun MD 2115 Kaneva 31. Date filed (Month, Day, Year) State 09 Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Calvin Earl Hanson 3, 2007 11:47 A M May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1 X M 2 □ F Director 212-12-9341 86 Maryland Oct. 13, 1920 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 智 a or 28a-f sho be notified a Director 1 □Yes 2 X No Maryland Harford Fallston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 505 Whitaker Mill Rd. 21047 USA the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: "natural", or 1 ☐ Yes 2 1 No Specify. ģ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Owner/Operator Dairy Farm Health and Mental Hygid tem 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Earl Hanson Helen Elizabeth Ford 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau Lillian Hanson/ Wife 505 Whitaker Mill Rd., Fallston, Maryland 21047
Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Bel Air Memorial Gdn. 5-7-07 4 ☐ Donation 5 ☐ Other (Specify) Bel Air, Maryland 21. Sid 22. Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Que to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner vonavi that initiated events resulting in death) Last physician and the burial-tr Due to (or as a consequence of Physician/Medical as attending IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 □Ectopic pregnancy for Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a ☐Yes 2☐No 9☐ Unknown 9 Ulnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 24a Wasan 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To nours after death.

neral Director: After this filled in by the funeral d 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours af

To the Funeral D

completely filled i rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

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30. Normand add bis of person who completed souse of death (Item 23a) (Type, Print)

2007

32 Registrar's Signature

07-03518 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Walter R Humple, Sr. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day May 7, 2007 **Medical Examiner** 1537 hrs R. Humple, Sr. Walter 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Sinai Hospital Baltimore 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** 6. Sex If Under 1 Year If Under 24Hrs. Months Hours Days Min Director Country) August 29,193 214-30-4620 1 X M 2 MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 X No MD Carrol1 Sykesville with the Maryland Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 711 Central Ave 21784 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S 14. Race - American Indian, Black Armed Forces? White, etc. hours after death Married Never Married 2 X Yes es, Give Yea Yes 2 X No specify: Widowed 4 X Divorced Specify White "natural" 3 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) h and Mental Hygiene.
27 is marked other than "n Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filted within 72 lent of Health and Mental Hygiene.
ant: If item 27 is marked other than ", no other traumatic event, the Medical I. MD 21215-0036 Carpenter Building 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Walter Humple Daisy Grimm 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Milton С. Hump1e Son 130 Carnival Drive, Taneytown, MD 21787 Baltimore, 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State permit. Pages
Department or
Important: I Mt. Paran Cemetery 5/11/07 Donation 5 Randallstown, MD Other Specify 22. Name and Address of Facility 11824 Reisterstown Road Eline Funeral Home Reisterstown, MD 21136 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line Between Onset and /Medical Death a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease xamine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause Examiner Due to (or as a consequence of) (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and The law requires that the death certificate be executed Physician/Medical UNPENDED attending physician or use as the burial -AMENDED Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ö 23e. Did tobacco use contribute to the cause of death? <u>۾</u> م 1 Yes 2 No 3 Probably 4 V Unknown Completed Records. certificate has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? Yes 2 1 🗸 Hospital or Attending Physician: 26.Place of Death (Check only one) 25. Was case referred to medica Division of Vital Be DOA this Inpatient 2 FR/Outpatient 3 Nursing Home 5 Residence 6 Other: မ 1 V Yes After t 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: 1 V Natural Pending Investigation Yes 2 No Director: within 24 hours after death.

To the Funeral Director:
completely filled in by the f 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 8, 2007

State

30. Name and address of person who completed cause

Pay, Yaar) 2007

Theodore M. King, Jr., MD.

31. Date filed (Month

111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

82 Registrar's Signature

			1 - For State Registrar	State of Ma	ryiarid /		nent of F icate of i		ina ivie	, ,	JIENE Reg. No.?	0.7	11051	
	ă.	May .	Decedent's Name (First, Middle, Last)					2	. Date of Dea	ith CU		3. Time of Death	
- P.C.	Physic /Medi			Robert	Louis	Henle	Эy		l N	Month May 1,	2007	Y <i>e</i> ar	12:30 p ^M	
	Exami		4a. Facility Name (If not institution, give			4b	. City, Town, or	r Location o			4c. County	y of Death	E	
		e .	13112 North Point				aurel				Prin	ce Ge	eorge	
С	Funeral		5. Social Security Number 6. Se	ЙМ 2ПЕ	(In yrs. last b		Under 1 Year onths Days	If Under 2 Hours	Min.	Date of Birth (Month, Day	, Year)	9. Birthp	place (State or Foreign ntry)	
	Director		295-38-3283 Usual Residence of Decedent		52	115.			J	July 3	0,1944		Virginia	
	/land ow at		10a. State 10b. County		10c. City, Tox	wn or Locatio	n					1	Od. Inside City Limits	
	Mary I-f sh fied	į	MD Prince (George	Laure	1							1 ☐ Yes 2 ☑ No	
	h the r 28a	irec	10e. Street and Number			1-	Of. Zip Code				l0g. Citizen of	What Cour	ntry?	
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28e-f show he Medical Examiner must be notified at	Funeral Director	13112 North Point	Lane			20708			İ	U.S.A.			
	ems er m	ıner	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S.	13. Was	Decedent of H	ispanic Orig	jin? (Specif	y Yes or No-		ce - Americ		
98	or it		1 ☐ Never Married 2 ☒ Married	1 XYes 2 No If Yes, Give			res 21 <mark>2</mark> No	Specify:	, r deno rue	an, e.c.)		ck, White,	etc.	
Maryland 21215-0036	hours ural"	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:							Specif	вта		
15-	n 72 "nat	Completed	15. Decedent's Edu (Specify only highest grad		168	a. Decedent's Give kind life DO N	s Usual Occup of work done o IOT use retired	ation <i>during m</i> ost	of working		16b. Kind of B	usiness/Ind	dustry	
12	withi lene. thar	l iii	Elementary/Secondary (0-12)	College (1-4or 5+) 4						vestigator U.S. Government				
D	Hyg Hyg other ent, i	Be C	17. Father's Name (First, Middle, Last)								Maiden Surnar		IIIIGIIC	
la la	lid be lenta ked ic ev	To B	Everett Winslow F	Tenley				Cece	elia D	a Dickerson				
ary	shou and N s mai	_	19a. Informant's Name/Relationship (T)	rpe. Print)	19	b. Mailing Ac	Idress (Street	and Number	r or Rural F	Route Numbe	Code)			
Σ,	is 1 and 2 of Health a item 27 is other trai		Ruby M. Henley /	spouse		13112	North E	Point	Lane,	, Laurel, Maryland 20708				
ore	of He fiten		20a. Method of Disposition	Computed from State	20b. Place o	of Disposition ery, cremator	(Name of ry or other plac	e)	Date	9	20c. Location	City or To	wn, State	
<u>Ē</u>	Pag ment ant: I ury o		4 Donation 5 Other (Specify) MD Veterans Cemetery May 7, 20							2007	Crownsv	ille,	Maryland	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.		21. Signature of Funeral Service Licens	1/		22. Na	me and Addres aldson	s of Facility	,		16.			
	⊈ 0 5 6 6		Now Home	l'E	M0077	73 313	Talbot	t Ave	. Lau	rel, M	Maryland	d 207	07-4389	
			23a. Part1. Enter the dispase, or compl shock, or heart failure. List only o	ications that caused the cause of the cause on each line.	n <i>e</i> death. Do	not enter the	e mode of dyin	g, such as o	cardiac or re	espiratory arr	est,		Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition resulting in death)	Metastat	ic Ren	nal Ce	ll Canc	er					Onset and Beath	
	/Medical Examiner		resulting in death)	Due to (or as a	consequence	of):	54							
		<u>.</u>	Sequentially list conditions,	Due to (or as a	consequence	off:								
	uted I Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			0.7.								
Ć,	execting and items in and items.	Еха	resulting in death) Last	Due to (or as a c	consequence	of):				<u> </u>				
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	rtifica ng ph as th		IF FEMALE.											
Вох	eath cert attending for use a	an/	Zob. Was decedent pregnant	3c. If yes, outcome pf 1□Live birth 2		h 3⊟Ecto	pic pregnancy					te of delive	•	
0	e des the at red fo	Physician/N	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at tir 9□Unknown	me of death		er (specify)				Mc	onth	Day Year	
<u>.</u>	that the de ned by the s detached t		Part II. Other significant conditions con	atributing to death but	not reculting	in the underly	das souss sive	on in Deat I	- 1	00- Did 4-1			44.440	
or Vital Records,	The law requires that the death ate has been signed by the atten age 2 should be detached for u	by	Tarkii. Salisi Sigiiinsalii Solialiisi Sol	taibuting to death but	not resulting	in the underly	ring cause give	mini Fanti,		23€. Did to			e cause of death? ably 4 Unknown	
Ö	w requires to be a signer should be a	Completed							- 1			3 F 100	ably 4 DOIRHOWN	
Be	has ge 2 s	ם							_	24a. Was a autops	y I	prior to cor	osy findings available npletion of cause of	
a			OF West and the state of the last								M No	death? 1 ☐ Yes	2 XX Io	
⋚		Be	25. Was case referred to medical examiner?	lospital:			TDOA Othe			heck only on				
0	Phys er this eral dii	5	1 ☐ Yes 2 XXVIo	1 ☐ Inpatient 28a. Date of Injury	28b.	utpatient 3		4 LI Nurs			ence 6 Oth		"	
0	Attending Pt r death. ector: After th by the funeral	ţ	1 Natural 5 Pending 2 Accident investigation	(Month, Day Y	(ear)	Injury N	28c. Injury Work	? ∕es 2 □ N		. E COOTIEC TIC	w mjary occan	· cu		
Division	A C S S	iţica	3 Suicide 6 Could not be determined	28e. Place of injury	- At home, fa	arm, street, fa	actory, office		28f.	Location (St	reet and Numb	er or Rura	I Route Number,	
	s afte	Certification:	4 [Tromicide	building, etc.	Specify)					City or Towr	, State)			
	To the Hospital or within 24 hours after To the Funeral Di completely filled in		29a. Certifier (Check only 2 Medical Exami	sician: To the best of a	my knowledg	e, death occi	urred at the tim	ne, date and	place, and	due to the ca	ause(s) and ma	anner as st	ated.	
	To the H within 24 To the F complete	Medical	5/10/	and manner state	d.									
	2 ¥ 2 ⊠	-	29b. Signature and title of certifier				29c. License			2	9d. Date signe		′	
			1 1/2					1139			May 7	, 20 ———	007	
ì	54		30. Name and address of person who co		,	,		Dkun	Col	umbia,	MD 21	044		
d.	Sta	e	31. Date filed (Month Day Year) 200			Fd	LUNCIIL	TVMÀ.		uma,	14D CT	-044		
	Sta		MAY U 9 200	Parice 1	18.	ansale	1							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** enisc 200 May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Dea Examiner Batte more 1405 Secours If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 213-92-4941 Days Months Hours 1 M 2 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 Des 2 No Director larylar 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3806 lurs Funeral Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cubap, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black. White, etc. permit. Pages 1 and 2 should be filled within 72 hours atter to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other transment. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3806 ricia Hicks Campbell-aunt Marylar 20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Zion Centley 20a. Metho Disposition - City or Twn, State 1 urial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens 23a. Part1. Enter the ase, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician MAGXIL /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): and burial-trar be exect Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home Hospital: 1 Yes 2 N 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To 5 ☐ Residence 6 ☐ Other (Specify) 28b. Time of 27. Manner of Death Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 / Natural 2 / Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certified 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAY 0 9 2007

M.D.

32 Registrar's Signature

W. Baltimore St.

hillip Regin	iald F	1	State of Maryland /	Department of Certificate of			Reg. No.	
A Phys		n/	egistrar I. Decedent's Name (First, Middle,Last)			2. Date of Dea	ath Day Year	3. Time of Death 0030 hrs
) Exa	amin		PHILLIP R. HIL 4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Locati	May 4, 20	4c. County of Deat	
			1000 Bonaparte Ave		Baltimore		NI/A	
Fune			5. Social Security Number 6. Sex 7. Age	e (In yrs. last birthday)		Inder 24Hrs. 8. Date of Bours Min.	irth(MM/DD/YYYY) 9. Bir Forei	
Direc	tor		216 62 5399 1x M 2 F	53 Yrs		AUG.	27,1953 M	TRYLAND
	ny		Usual Residence of Decedent 10a, State 10b, County	10c. City, Town or Loca	tion			10d. Inside City Limits
plant.	show a	_	MD. N/A	BALT	IMORE			1 X Yes 2 No
Aaryla:	or 28a-t show any fied at once.	Director	10e. Street and Number		10f. Zip Code		10g. Citizen of What Cou	intry?
th the	ns 23a or 28a-f sho be notified at ouce		1000 BONAPARTE AVE.	- Jun Hanw	212	18 Origin? (Specify Yes or N	USA	rican Indian, Black,
ath wi	st be	= 1	11. Marital Status 1 Never Married 2 Married Armed Forces?) If '	as Decedent of Hispanic Yes, specify Cuban, Mexi		White, etc.	
ifter de	l", or	by Fu	3 Widowed 4 Divorced If Yes, Give Year or Dates:	X No 1	Yes 2 No spe	cify:	Specify:	BLACK
hours a	natura Exami	ed b	15. Decedent's Education (Specify only highest grade con	during r	nt's Usual Occupation (G most of working life. DO N		16b. Kind of Business.	/Industry
36 iin 72	than "	Completed	Elementary/Secondary (0-12) College (1-4 or s		AINTER		SELF EMI	PI.OVED
5-00 ed with	other the Me	하	17. Father's Name (First, Middle, Last)			ther's Name (First, Middle		LOTED
121 d be fill lental F	arked event,	e Be	SAMUEL HILL 19a. Informant's Name/Relationship (Type, Print)	I 10b Maili	MA	ARY RUTH T Number or Rural Route No	EAL	e Zin Code)
ID 2 Shoul	27 is m matic	ř	DESIREE HILL (daughte:			AVE. BALTI		
e, N 1 and Health	r trau	Ì	20a. Method of Disposition	20b. Place of Dispo	sition (Name of cemeter)		20c. Location - City of	
MO!	ant: F		1 Burial 2 Cremation 3 Removal from St 4 Donation 5 Other Specify:	MARYLAN	D NATL.MEN	1.PK.	LAUREL	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.	mport		2) Signature of Funeral Service Licensee	22 C	Name and Address of Fa ALVIN B. S	CRUGGS FU	NERAL HOME	E
ysic		-/	23a. Part I. Enter the disease, or complications that caused	I the death. Do not enter	412 E. PRI the mode of dying, such	ESTON ST as cardiac or respiratory a	BALTO MD arrest, shock, or heart	21212 Approximate Interval
Medi	ical		failure. List only one cause on each line. Immediate Cause (Final disease a. Heroin into	xication & co	ocaine use			Between Onset and Death
Exami	ner	١	or condition resulting in death) Due to (or as a cons				-	
		Je	Sequentially list conditions, if any, leading to immediate b. Due to (or as a cons	equence of):				
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cuted	and transit	Ě	d					
. be exe	sician a	Medical			67, 5/10/07 TT			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	In/M	IF FEMALE: 23b. Was decedent pregnant in the cost 12 months? 23c. If yes, outco		Fetal death 3 E	ctopic pregnancy	23d. Date of delive Month	Pry Day Year
OX 6 ath cer	attendi or use	Physician/	past 12 months? 1 Yes 2 No 9 Unknown g Unknown	t time of death 5	Other (Specify)			
the de	by the	Phy	Part II. Other significant conditions contributing to dear	th but not resulting in the	underlying cause given	in Part I. 23e. Did	tobacco use contribute t	o the cause of death?
P.C	signed be deta	a p				1 🔲	/es 2 No 3 Pr	obably 4 🗸 Unknown
ords v requi	s been should	Completed					topsy prior to	autopsy findings available completion of cause of
Reco The lar	cate ha	mo				1 ✔ Ye	rformed? death? s 2 No 1	
tal 1	certifi rector,	Be	25. Was case referred to medical examiner?	ent 2 ER/Outpatie	Othe	eath (Check only one) Nursing Home 5	Residence 6 ✔ Oth	er' Scene
of Vi	ter this eral di	P.	1 V Yes 2 No 128a Date of Ini	iury 28b. Time o			be how injury occurred	
ending	or: Af	ij	1 Natural 5 Pending [Month, Day, 2] 2 Accident Investigation		:O1 am	² X No unk		
Division tal or Attendi	Direct I in by	Certification:	3 Suicide 6 X Could not be 28e. Place of I	njury - At home, farm, str house	reet, factory, office building	or Town	n (Street and Number or I n, State)	
ospital	ineral y fillec		4 Homicide determined (Specify) 29a. Certifier 1 Certifying Physician: To the best of r		surred at the time, date at		naparte Ave, Ba	
To the II	the F	Medical	one) Certifying Physician: To the basis of examiner: On the basis of examiner and manner stated	amination and/or investig	gation, in my opinion, dea	ath occurred at the time, da	ate and place, and due to	the cause(s)
	28	Me	29b. Signature and title of certifier		29c. License nu		29d. Date signed (M	fonth, Day, Year)
_			ane De		O.C.M.E		May 4, 2007	
DT			30. Name and address of person who completed cause of Ana Rubio MD. Assistant Medical Exal		Ştreet, Baltimore,	MD 21201		
V	S	ate	31. Date filed (Month, Day, Year) 32. Figure 32.	ar's Signatur	marks.			
R	egis	rar	MAY 0 9 2007	1200 - 17				

Registrar

			1 - State Registrar	State of Marylar		artment of Hartificate of I			giene	007	14954
	Physici /Medio		1. Decedent's Name (First, Middle, Las ROOSevel +			Hender	rsan	2. Date of Dea	$\frac{\partial}{\partial I}$	20°7	3. Time of Death
	Examir Funeral Director	er	4a. Facility Name (If not institution, give 5. Social Security Number 6. S. 430–42–3667	cal con	la st birthday,	4b. City, Town, or Bull 1990 If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birt	h Year)	d Coun	lace (State or Foreign try) AR
	· ·		Usual Residence of Decedent					UAN. IC	192		
	Aaryla I ehov	-	10a. State 10b. County		ity, Town or L					1	0d. Inside City Limits 1 XYes 2 □ No
	28a-	Director	MD 10e. Street and Number	BAL	JTIMORE	10f. Zip Code			10a. Citizei	n of What Coun	
	th with		419 E. LAFAYETTE	ST.		21202			USZ	Α	· ·
980	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, it is Medical Examinar marks rectified at	by Funeral	11. Maritat Status 1 Never Married 2 Married 3 Widowed 4 ADvorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	J.S. 13.	Was Decedent of Hilf Yes, specify Cuba 1 ☐ Yes 2 🔀 No	ispanic Origin? (S n, Mexican, Puerl Specify:	pecify Yes or No- to Rican, etc.)	14.	Race - Americ Black, White, becify: BLAC	etc.
21215-0036	within 72 ho	Completed	15. Decedent's Ed (Specify only highest grade) Elementary/Secondary (0-12)	ucation de completed) Cottege (1-4or 5+)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	during most of wo	rking		of Business/Inc	•
9	filed with Hygier Sther the		17. Father's Name (First, Middle, Last)		TRU	ICK DRIVER		ne (First, Middle,		ACTOR TI	RAILER
/lan	Mental Merked Marked	To Be	un				ELIZA F			,	
Maryland	2 sho and h is me		19a. Informant's Name/Relationship (7	ype, Print)	19b. Maili	ng Address (Street a			r, City or T	own, State, Zip	Code)
	1 and Health em 27 ther to		YVONNE LACEY/FRIED 20a. Method of Disposition		419	E. LAFAY	ETTE ST.	, BALTIM	ORE,	MD 212	
סר	Pages nent of int: If it iry or o		1 ☐ Burial 2 【**XCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	cemetery, cre	matory or other place				tion - City or To O DONNE	
Baltimore,	permit. Pages Department of Important: If it eny Injury or one.		21. Signature of Fun ral Solvice Licen	4		VIEW 2. Name and Addres	s of Facility WE	SLEY CHA	VIS,	MORE, M JR. FNR	D 21224 L. HM.
	20200		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of	dications that caused the dea		2007-09 1	EASTERN	AVE., BA	LTIMO	RE, MD	21231 Approximate
	Physician /Medical Examiner		shock, or heart failure. List only of tmmediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consec	Ile	10.	luna				Interval Between Onset and Death
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.O. Box	The law requires that the death certific te has been signed by the attending page 2 should be detached for use as	Physician/M	tF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnance 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of decentions	Il death 3[Ectopic pregnancy Other (specify)			23d	. Date of delive Month	ry Day Year
ds, P.	uires that i signed b id be deta	P	Part II. Other significant conditions co	ntributing to death but not res	sulting in the u	nderlying cause give	on in Part I.			contribute to the	e cause of death?
COL	s been si	olete						24a. Was a			sy findings available
Vital Records,		Completed						autops perfor 1 Yes	SV	prior to con death?	ppletion of cause of
\rightarrow	Physician: this certifica ral director, p	o Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{Yes} \)	Hospital:	ER/Outpatier	othe	· ·	th Check only or	-		
Division of	g = = -	ation; To	27. Manner of Death 1	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	28c. Injury Work	4 🗆 Ivursing 🗆	ome 5 Residence 28d. Describe he)
N N	To the Hospital or Attendi within 24 hours after death. To the Funersi Director: A completely filled in by the fu	Certification;	3 Suicide 6 Sould not be determined	28e. Place of Injury - At h building, etc. (Specif	y) 			28f. Location (Si City or Town	n, State)		
	ne Hosp n 24 hou ne Funei	edicai	29a. Certifier (Check only one) 1 Certifying Phy	sician: To the best of my knowner: On the basis of examination and manner stated.	wledge, deatl ition and/or in	n occurred at the tim vestigation, in my op	e, date and place inion, death occu	, and due to the c rred at the time, d	ause(s) and ate and pla	d manner as sta	ited. the cause(s)
	To the within 2 To the complet	X	29b. Signature and title of certifier	7).		29c. License	number	2	9d. Date si	gned (Month, D	Day, Year)
			Muen a.	Korshed	W	DYC	744		Hou	1 21,	2007
			30. Name and address of person who co	ompleted cause of death (tten	n 23a) (Type,	eral Co	ulu	301 4	Parel	19 2	al to liet
þ	Sta	ie.	31. Date filed (Month, Day, Year)	32. Registrar's Signa	iture		UPW.	201 11	, 500	11.	21202
·è	Registra	ar	MAY 0 9 2007	Flaces St	600340	100					

7-03475 /ernon Edward Jovce

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 14955

	1-	For State		Certific	cate of L	Death			Reg. N	0	3. Time of Death
ysicia	n/ 1	e gistrar . Decedent's Name (First, Middle,La	ast)					Month	of Death	y Year	1343 hrs
xamir غ	ner	VERNON EDWARD JO	YCE						6, 2007	4c. County of De	eath
	4	a. Facility Name (if not institution, g			46	. City, Town, or L Glen Burnie	ocation of t	Jeath		Anne Aruno	
		102 Crain Highway North					Life Line does 1	DAHro Is Dat	e of Birth (M		Birthplace (State or
Funeral		. Social Security Number 6.	Sex 7. Ag	je (In yrs. last b	irthday)	If Under 1 Year Months Days	_	1.65-		IFC	reign Country) MARYLANI
Director		217-20-7076	M 2 XF	80	Yrs.	Months Days		JU:	LY 28	. 1926	MARILANI
	- 1	Isual Residence of Decedent									10d. Inside City Limits
any		0a. State 10b. County		10c. City, Tov	vn or Locatio	n					1 Yes 2 X No
d d		MARYLAND ANNE AR	RUNDEL	GLEN F	BURNIE					Citizen of What	Country?
rylan a-fs	용	10e. Street and Number				10f. Zip Code					
te Maryland or 28a-f show any <u>fred at once.</u>	Director	102 N. CRAIN HWY	7., APT. 91	.2		21061				ITED STA	
ith th 23a noti	崇	11. Marital Status	12. Was Deceden	nt Ever in U.S.	13. Was	s Decedent of His es, specify Cuban	panic Origin	n? (Specify Ye	es or No- etc.)	14. Race - A White, e	merican Indian, Black, tc.
ath w	Funeral	1 Never Married 2 Marr	ried Armed Forces	s? 2 💢 No	II Ye	es, specify Cuban	i, Mexican,	derio (dour.)			****
er de	리	3 Widowed 4 X Divorce	ced If Yes, Give Year			Yes 2 X No				Specify: 6b. Kind of Busin	WHITE
rs aft ural	≦	15. Decedent's Education (Specif		ompleted) 16	a. Deceden	t's Usual Occupatost of working life	tion (Give ki	ind of work do use retired)	ne 11	bb. Kind of Busin	ess/industry
"nat	Completed	Elementary/Secondary (0-12)	College (1-4 or							OIL IND	TCTDV
36 nin 72 e. than sdical	g	8			DRIVE	ER					JSIKI
with year	팃	17. Father's Name (First, Middle, L	ast)							iden Surname)	ME
215-0036 be filed within 7 ntal Hygiene. rked other than rent, the Medics	Be	VERNON AUSTIN JO	OYCE			g Address (Stree	THEL	1A KATH	EKINE	HARTLI	State, Zip Code)
212 Men Men mar	10	19a. Informant's Name/Relationshi			19b. Mailing	g Address (Stre	et and Num	DACA	DE'NA	MADVI A	NID 21122
AD 2 sho		JAMES EURICE/ FI	RIEND		365 E	CAGLE HI.	LL KD	Date	DENA,	20c. Location - C	ND 21122
and and lealth		20a. Method of Disposition	a Dameuel from	0.00	ce of Disposematory or ot	sition (Name of ce her place)	emetery,	MAY 8,			
DOF ges 1 it of 1 t: If other		1 Burial 2 X Cremation				EMATORY,	INC.	2007		CATONSV	ILLE, MARYLAN
t. Partmen		Donation 5 Other Specific Journal Service J	icensee		22.	Name and Addres	s of Facility	/	OAT HO	мг р Δ	
Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 72 hours after death with the Maryland pepernit. Pages I and 2 should be filed within 72 hours after death with and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot injury or other traumatic event, the Medical Examiner must be notified at once.			X		K.	IRKLEY-R 21 CRAIN	HWY.	S.E.	GLEN	BURNIE	MD 21061 t Approximate Interv
		23a Part I. Enter the disease, or o	complications that caus	ed the death. D	o not enter	the mode of dying	g, such as c	ardiac or respi	iratory arres	t, shock, or near	Between Onset and
ysician /Medica		failure. List only one cause of	on each line.								Death
Examine		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a co								
			b.								- 1
	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a co	onsequence of):	:						
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tal Records, P.O. Box 68760, cian: The law requires that the death certificate be executed certificate has been signed by the attending physician and certificate has been signed by the certificate has been signed by the certificate has been signed by the certificate has been signed by the certificate has been signed by the certificate has been signed by the certificate has been signed by the certificate has been signed by the certificate has been signed by the certificate has been signed by the certificate has been signed by the certificate has been signed by the certificate has been signed by the certificate has been signed by the certificate has been signed by the certificate has been signed by the certificate has been signed by the certificate has been signed by the certificate has been signed	ledical	UNPENDED			anav.					23d. Date of	
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68 Sertificanting	ian la	past 12 months?		nt at time of dea		Other (Specify)				ŀ	
Box 687 e death certific the attending p	Physician	1 Yes 2 No 9 Uni	known 9 Unknow						no Dida	hanna uga cantri	bute to the cause of death?
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	1 - For State Registrar	State of Marylar		artment of rtificate o			lygiene Reg. No.	007	14956
Physician /Medical		JENKIN	S			2. Date of Month	Day	2007	3. Time of Death
Examiner Funeral Director	Franklin Woods 5. Social Security Number 6.5	Nursing Cer		4b. City, Town RC If Under 1 Yea Months Day	sedale			Baltimor 9. Birthpl Coun Vin	ace (State or Foreig
	Usual Residence of Decedent 10a. State 10b. County	Į.	ty, Town or Lo			Duly 2			Od. Inside City Limit
	10e. Street and Number 317 Southeastern	l'errace		10f. Zip Code	21221		10g. Citize	en of What Coun	try?
urs after alf, or ite xanctor by Full	3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Yes, specify Co		gin? (Specify Yes or i, Puerto Rican, etc.)		Race - Americ Black, White, e Specify: Whi	etc.
within and then the Mer	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 10	ducation ade completed) College (1-4or 5+)	(Give	dent's Usual Occ kind of work dor DO NOT use reti E Instal	ne during mos red)	t of working		of Business/Ind	
be fill H d ott	17. Father's Name (First, Middle, Last)				er's Name (First, Midd e Lena Ya		umame)	
es 1 and 2 should of Health and Mer item 27 te marke r other traumatic	19a. Informant's Name/Relationship (Renee Sotelo (Gran	nddaughter)	317 9	Southeas		er or Rural Route Nur Cerrace Ba	ltimore	e, Maryla	and 21221
Page nent o ant: If ury or	20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special	Removal from State (y) Hol	cemetery, cren Lly Hil		ardens	Date 5/10/2007	Balt:	ition - City or Tor LMore, M	
permit. Departr Importa any inji	21. Signature of Funeral Service Lice	rkouske	14	407 Ola	Easter	eral Home n Avenue	Essex,	Marylar	d 21221
Create be executed Wedical Examiner Coloral Examiner	23a. Par 1. Enter the disease, or combody, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intiated events resulting in death) Last	b. Due to (or as a consequence of the consequence o	quence of):	my the	nia Dise	?ase			Interval Between Onset and Death
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The law ate has b page 2 st						pe 1□ Yes	rformed? s 2/2 No	24b. Were autop prior to con death? 1 ☐ Yes	osy findings availab npletion of cause o 2 No
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To the Hospital within 24 hours a To the Funeral Completely filled i		ysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, death	restigation, in my	opinion, dea	d place, and due to the time to the time.	e, date and p	lace, and due to	the cause(s)
	29b. Signature and title of certifier 30. Name and address of person who	completed cause of death (Item	n 23a) (Tvpe. l	7	onse number	3/	29d. Date	signed (Month, E	Day, Year)
State Registrar	Regive Can-Ca 31. Date filed (Month, Day, Year) MAY 0 9	orden, MD, 910 32. Ragistrar's Signa	ature	nldin	Squay	Pr, Ste 3	19, B	alto, 1	40 2/23

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** Month Year 3P M Bertha Jakum 200 7 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TIZENS Havee De If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) September 8 1915 Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Days Hours 1 ☐ M 2 ☐ F Baltimore, Md. 215 07 0296 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at Director 1 ☐Yes 2☐No Maryland Harford Bel Air 10e. Street and Number 10g. Citizen of What Country? 10f Zip Code 1007 Prospect Mill Road 21015 USA Funeral "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. ģ 3 XWidowed 4 Divorced White Completed the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
Technician Electronics 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hyglene Important: If Item 27 Is marked other the any Injury or other traumatic event, the one. Westinghouse Assembly Line 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter Wojtasik Anna Melanowski ٥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William W Jakum 1007 Prospect Mill Road Bel Air, Md. 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XX urial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cem May 7 2007 Baltimore, Maryland 21. Sometive of Funeral Service Licensee 22. Name and Address of Facility
EF Lassahn Funeral Home PA 11750 Belair Road Kingsville, Maryland 21087 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreshock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ormai /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical attending p 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 ₩6 Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Thursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

D

S. UNION AVE

HAURE DE GRACE, MD.

M.D.

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8- GAL

0 9 2007

31. Date filed (Month, Day, Year)

07-03472 James F. Johnson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 14958

es (. c om			For State	0.0		,	Cert	ificate of	Death				R	eg. No.				_
Physic	rian		Decedent's Name	e (First, Middle,	Last)								Date of Dea Month	Day	Year		Time of Death 1032 hrs	
Exan			James	Frede	cick	Johns	on, Jr						May 6, 20	07	0	(Death	10321113	-
		4:	a. Facility Name (i		give street a	nd number)	4	b. City, Too Middle		cation of	Death		1	County of Baltimore		ty	
		Ļ	23 Old Knife			7.0	ge (In yrs. las	et hirthday)	If Under		If Under	24Hrs.	8. Date of Bi	rth(MM	/DD/YYYY)	9, Births	lace (State or	\neg
Funera Directo		5	Social Security N 217 74 3	1550	5. Sex		3	Yrs	Months	Days	Hours	Min.	October			Foreign Coun	Salisbury,	
			Isual Residence o		1 101 2					'								
any		_	0a. State	10b. County			10c. City, 1	Town or Locat	ion							1	1 Yes 2 N	
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Maryland 28a-f show	i l	밁	0e. Street and Nu	mber					10f. Zip (Code				10g. Ci	tizen of Wh	at Countr	ry?	
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with a	е по	<u>e</u> 1	1. Marital Status		۸.	as Deceder	nt Ever in U.\$	5. 13. Wa	s Deceden	t of Hisp Cuban,	anic Origi Mexican,	n? (Spe Puerto R	cify Yes or N Rican, etc.)	lo-	14. Race White		an Indian, Black,	- 1
hours after death with the Maryland "natural", or items 23a or 28a-f sho		Funeral	1 Never Marri	ied 2 Ma	1	Yes	2 X No								Specify:	المخطارا		1
after al., o	in in	<u>~</u>	3 Widowed		rced If Yes, C		lated\ I	16a. Decede	Yes 2			ind of wo	ork done	16b.	Kind of Bu	Whit Isiness/In		\dashv
hours	E .	<u> </u>	15. Decedent's E			llege (1-4 o		during n	nost of work	ing life. I	DO NOT	use retire	ed)					
136 hin 72 e. than "	lici.	Completed	Elementary/Sec 12	ondary (0-12)		N/A	,	Steel V	Vorker						eel In		ν	
5-00; ed with tygiene other t	e Me	탉	17. Father's Name	(First, Middle,	Last)					1			(First, Middle	, Maide	n Surname)	-	
21215-0036 uld be filed within 7 Mental Hygiene.	뷥	Be	James F	rederick	Johnson	n Sr					Jane	t Har	nby		- T	Chata	7:- Codo	4
2121 hould be fill and Mental I	ic eve	ᆰ	19a. Informant's N	lame/Relations	nip (Type, Pr	int)							ural Route N				Zip Code)	İ
e, MD 3 1 and 2 shot Health and item 27 is	umat			a Lynn Ti)11		205	Place of Dispo				атсш	Date Date	200	. Location	- City or	Town, State	ᅥ
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland anter of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho	or other traumatic event, the Medical	ı	20a. Method of Di	Sposition Cremation	3 Re	noval from	State	crematory or o	ther place)									
Page nent o	or of	1	4 Donation	5 Other Sa	ecify:		Gar	dens of	Faith Name and	Cem.	May 1	0 200	07	i_E	altimo	re,Ma	ryland	\dashv
Baltimore, M permit. Pages 1 and 2 Department of Health Important: If item 2	injury	Ī	21. Signature of F	uneral Service	Licensee			11/	nccobn	Euron	ഹി ഥം	vmo Tr	nc	-				- 1
111		4	23a. Part I. Enter	the disease, or	complication	s that caus	ed the death	. Do not enter	the mode of	air. of dying,	Such as c	ardiac o	respiratory	arrest, s	hock, or he	ant and	Approximate Inter Between Onset a	
nysici: Vledio		١	failure. List o	only one cause	on each line		lyocardial										Death	
£xamin	er		Immediate Cause or condition result	e (Final disease Iting in death)			nsequence o											
			Sequentially list of	conditions,			ery Throm										 	\dashv
		iner	if any, leading to cause. Enter Un	immediate	Due to	or as a co rtensive	Atherosc	erotic Car	diovascu	lar Dis	sease							
		Examine	(Disease or injury events resulting				onsequence o											
and souted	the burial - transit				d													\neg
be exe	urial	Medical	UNPENDE	D		NDED									23d. Date	of deliver	<u> </u>	\dashv
760 ficate b	the b	Ž	IF FEMALE: 23b. Was decede	nt pregnant in t	he 230	Live birt	tcome of pre	gnancy 2	Fetal death	3	Ectop	ic pregna	ancy		Month	,	Day Year	
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Box e death c	hed for	Physi		No 9 Ur		Unknow		talon o los abo	o un dorbino	- cours	given in F	Part I	23e. D	id tobac	cco use cor	ntribute to	the cause of death?	?
P.O.	수	by P	Part II. Other sig	nificant condi	tions conti	ibuting to d	eath but not	resulting in th	e underrying	y cause :	giveiiiii						bably 4 🗸 Unknow	
S, P	ld be deta	edt												Vas an	24b	. Were a	utopsy findings avail completion of cause	lable
ord w req	nas been 2 should	plet						<u> </u>					p	utopsy erforme		death?		
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EZ	certificate ector, page	Be (25. Was case re examiner?	ferred to medic	al Hospit	al: ,	patient 2	ER/Outpati	ent 3	DOA	Other ₄		ng Home 5	Re	sidence 6	Oth	er: Scene	
of Vital	dir di	To	1 ✓ Yes 27. Manner of D	2 No		28a. Date o		28b. Time			ury at Wo				v injury occ	urred		
ding	After t funeral	O.	1 V Natural		nding	(Month, I	Day,Year)			1	Yes 2	No	}					
Sio Atten r deat	ector: by the	icati	2 Acciden	t Inv	estigation	28e. Place	of Injury - At	home, farm, s	treet, factor	y, office	building,	etc.		on (Strewn, Stat		nber or R	Rural Route Number,	City
Division tal or Attendi	eral Direct filled in by	ertification:	3 Suicide 4 Homicio	det	uld not be ermined	(Specify)												
Division of Vital Records, P.O. Is To the Hospital or Attending Physician: The law requires that the within 24 hours after death.	Funer tely fil	ပ			Physician:	o the best	of my knowle	edge, death o	curred at th	ne time,	date and	place, an	d due to the	cause(s) and man	ner as sta	ated. the cause(s)	
o the	To the Fur completely	Medical		Certifying Medical Ex	anu	the basis of manner sta	f examination ated	and/or invest					at the time,	1 2	29d. Date s	igned (N	Ionth, Day, Year)	
	F 5	ž	29b. Signature	and title of certi	fier	i/ 1	15		2		nse numb C.M.E.	01			May 7, 2			
			1/10	ing B	assel	1,00	115			0.0	7. IVI. L							
5	}		30. Name and a			leted cause	e of death (Ite dical Exan	em 23a) ni ne r 11	1 Penn S	Street.	Baltimo	ore, MI	21201					
			Or Date Olast (Brassell, MI			-											
	S	tate	31. Date filed (A	vioritii, Day, rea	้ ๑๋ วกก	7	strar's Sign	15	B 1548									

			For State Registrar	State of Maryland			lental Hygi	ene g. No.2 0 0 7	11.959
	Physici /Medio Examir	al	1. Decedent's Name (First, Middle, Last) 4a. Facility Name (If not institution, give s 5. Social Security Number 6. Sex	HOSPITA	TO HNS a 4b. City, Town,	or Location of Death	2. Date of Death Month MAY	Day Year 6 2007 4c. County of Death	3. Time of Death
	Funeral Director			[M 2 F 87	Yrs. Months Days	Hours Min.	8. Date of Birth (Month, Day, November	18,1919 Ma	lace (State or Foreign try) aryland
	Maryland a-f show lifed at	tor	10a. State 10b. County Maryland Baltimore		own or Location timore			. 10	0d. Inside City Limits 1 ☐ Yes 2 🃉 No
	th with the 23a or 28i ist be not	al Direc	10e. Street and Number 6825 Campfield Rd.	, Apt. 6B	10f. Zip Code 21207			g. Citizen of What Coun United Stat	•
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. It is Medical Examinating must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Amed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: WW II	13. Was Decedent of If Yes, specify Cut		ecify Yes or No- Rican, etc.)	14. Race - America Black, White, e Specify: Wh	
21215-0036	l within 72 ho liene. r than "natur the Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 1.2		6a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire engineer	pation during most of working d)	ng	6b. Kind of Business/Ind	
Maryland 2	noutd be filed I Mental Hyg harked other	To Be C	17. Father's Name (First, Middle, Last) Newton P. Johnson			18. Mother's Name Ruth Lei	(First, Middle, Mi Lmbach	aiden Surname)	
e, Mar	and 2 st lealth and m 27 is n		Jane Ely Johnson/w.	ife 6	9b. Mailing Address (Stree 825 Campfield	d Rd., Apt	. 6B Ba	altimore, M	D 21207
Baltimore,	Pages 1 Iment of H tant: If ite jury or ot		20a. Method of Disposition 1 ☐ Burial 2 XXCremation 3 ☐ Ri 1 ☐ Donation 5 ☐ Other (Specify)	BIIIOVAI IIOIII State	of Disposition (Name of stery, crematory or other pla Mount Crema	tory May 8	, 2007	oc. Location - City or Tow Ba1timore,	Maryland
Bai	Departition Depart		21. Signature of Funeral Service License	leff The same of t	0,000	TOLK RU.	Daitill		Inc. 212
	Physician /Medical Examiner		23a. Pard. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the death. De cause on each line. Due to (or as a consequence)	-OPD.	ng, such as cardiac o	r respiratory arres	E .	Approximate Interval Between Onset and Death
8760,	death certificate be executed e attending physician and of for use as the burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. First indication of Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	,				
O. Box 6	at the death certifica by the attending pt tached for use as the	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	Bc. If yes, outcome of pregnancy 1 Live birth 2 Fetel dea 4 Pregnant at time of death 9 Unknown		у		23d. Date of deliver Month	y Day Year
ecords, P	es tha igned be de	þ	Part II. Other significant conditions con	tributing to death but not resulting	g in the underlying cause gr	ven in Part I.		cco use contribute to the	
		Completed					24a. Was an autopsy performe	prior to com death?	sy findings available pletion of cause of
Vital	yaician: is certifica director, p	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 Anpatient 2 ☐ ER/0	Outpatient 3 DOA	26. Place of Death		ce 6 ☐ Other (Specify)	
ion of	ding Ph h. After th funeral	atlon; T	27. Manner of Death 1 Avatural 5 Pending investigation	THE RESERVE TO SERVE THE PARTY OF THE PARTY	Time of 28c. Injury Wo		8d. Describe how		
DIVISION	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	2	8f. Location (Stre City or Town,	et and Number or Rural State)	Route Number,
)	the Hospital hin 24 hours a the Funeral I mpletely filled	edical	29a. Certifier (Check only one) 1 Certifying Physical Exemination (Check only one)	ician: To the best of my knowled er: On the basis of examination and manner stated.	ge, death occurred at the til and/or investigation, in my o	me, date and place, a ppinion, death occurre	nd due to the cau d at the time, date	se(s) and manner as sta e and place, and due to t	ted. :he cause(s)
ı	To the within to the comp	ž	29b. Signature and title of certifier	uni ly	29c. Licens			I. Date signed (Month, D	* .
	6		30. Name and address of person who cor	npleted cause of death (Item 23a	(Type, Print) AL		172		
	Sta Registra		31. Date filed (Month, Day, Year) MAY 0 9 2007	2. Registrar's Signature	Late				

State of Maryland / Department of Health and Mental Hygiene 14960 Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Day **Physician** 2, 7:10 AMM Frank C. Jones May 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 416 Hillsboro Dr. Silver Spring Montgomery 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Date of Birth (Month, Day, Year) Days 1.⊠M 2□ F Months Hours Min. 74 Director 464-36-0221 07/30/1932 TXUsual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f show idical Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 416 Hillsboro Dr. 20902-United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 ☐ Yes **2** If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married No No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 2 Specify Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Federal Government permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any Injury or other transmett. Elementary/Secondary (0-12) College (1-4or 5+) Theoretical Physicist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Kenneth Jones Nancy Culver ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ardythe G. Jones/Wife 416 Hillsboro Dr. Silver Spring, MD 20902-20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Mav 4 □ Donation 5 □ Other (Specify) Beltsville, Maryland Chesapeake Crematory 2007 21. Signature of Funeral Service Licences 22. Name and Address of Facility Rapp Funeral & Cremation Services 933 Gist Ave. Silver Spring, Maryland 20910-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Adeno Carcinoma with Metastasize to the Bone **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown þ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s autonsy perform certificate 1∐ Yes 2X No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home SA Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P this 27. Manner of Death 28a. Date of Injury 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 Pending investigation 1.XNatural the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the within 2 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D45880 05-03-2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1396 Piccard Dr. Rockville, MD 20850 Leon C. Hwang 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

			1 - State Amend #30, perDV	State of Mary R, G867, 5/9/0	land / Depa	artment of h	Health and I	Mental Hy	giene	11.961	
	Registrar 1. Decedent's Name (First, Middle, Last)							2. Date of Dea		3. Time of Death	
	Physician Perry Albert Jordan					и		Month Mav	Day Year 2007	10:00AM ^M	
	/Medical						c. City, Town, or Location of Death				
	Examili	eı	728 Templecliff Ro		esville		Baltimo	re			
	Funeral		5. Social Security Number 6. Sex	7. Age (In	yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.		h 9. Birth	place (State or Foreign	
	Director		220-16-0686	(M 2□F	82 Yrs.	Months Days	Hours Min.	Jour.	24,1925	Maryland	
	D .		Usual Residence of Decedent 10a. State 10b. County	10	c. City. Town or Lo	nation				10d. Inside City Limits	
	aryla ehov	5								1 Yes 2 No	
	Ne M	Director	MD Baltimo	ore	Pike	esville			10g. Citizen of What Co		
	with t	늅		_		101. Zip C009	21222			and y :	
	eath ne 23	era	728 Templecliff F	Road 12. Was Decedent Ever	rin II S 13 1	Was Decedent of I	21208 Hispanic Origin? (S	pacify Yas or No-	USA 14. Race - Amer	ican Indian.	
	ter d	Funeral	1 Never Married 2 Married	Armed Forces?		f Yes, specify Cub	an, Mexican, Puert	o Rican, etc.)	Black, White		
93	urs a	by	3 ☐ Widowed 4 ☐ Divorced	1 ☑Yes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:		Specify:	hite	
Ŏ	within 72 hours after death with the Maryland ene. then "natural", or iteme 23s or 28s-f show ha Medical Exacitinar mast the notified at	Completed	15. Decedent's Educ	cation	16a. Dece	dent's Usual Occu	pation during most of wor	king	16b. Kind of Business/I	ndustry	
2	thin 7	nple.	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	nd)	~~··g			
2	ed wi	ပ်	8		Corre	ctional	Officer		Law enforc	ement	
nd	d oth	Be	17. Father's Name (First, Middle, Last)	_					Maiden Surname)		
<u>y</u> a	ould Men Marke Marke	ဥ	William Franklin		-		1	e Hyatt			
Maryland 21215-0036	Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene. snt: If Item 27 is marked other then "natural", or Iteme 23a or 28a-1 ehow ury or other traumatic avent, the Medical Exactinal mast be redified at		19a. Informant's Name/Relationship (Typ						or, City or Town, State, Z		
e,	1 and Healt em 2		Gladys Jordan 20a. Method of Disposition	Wife	728 Ob. Place of Dispo		iff Road,	Pikesvi Date	20c. Location - City or	208 Town, State	
Ď	ages nt of nt of nt of		1 N Burial 2 □ Cremation 3 □ R	emoval from State	cemetery, crer	natory`or other pla	1	107			
Baltimore,	it. Partme		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License		Garrison	FOTEST V		9/07	Owings Mi		
Ba	permit. Pag Depertment Important: I any Injury o		K- A &	Lune			eral Home		Reistersto erstown, MD		
	_		23. Part1. Enter the disease, or complic	cations that caused the						Approximate	
	Dhysisian	1	shock, or heert failure. List only on Immediate Cause (Final	e cause on each line.		. /				Interval Between Onset and Death	
	Physician /Medical		disense or condition resulting in death)	Due to (or as a co	inservence of):	ncer_					
	Examiner		Sequentially list conditions, b. Due to (or as a political party)								
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Y	icate be executed physicien and s the burial-transit	Exami	Cause (Disease or injury) that initiated events c.								
Ö,	ate be executed hysicien and the burial-transit	Ä	resulting in death) Last Due to (or as a consequence of):								
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9	death certific e attending pl d for use as t	ě l	IF FEMALE:	20 Huga autaoma of m							
Box	ath c	lan	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time	Fetal death 3	Ectopic pregnand	у		23d. Date of deli Month	very Day Year	
o.	the de ny the a	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	e or death 5	Other (specify) _					
۵.	that the de led by the a detached i		Part II. Other significant conditions con	s contributing to death but not resulting in the underlying cause given in Part I.				23e. Did to	I tobacco use contribute to the cause of death		
sp	es De	d by						1 🗗	es 2 No 3 Pro	bably 4 Unknown	
00	w requir been s should	lete						24a. Was	an 24b. Were au	topsy findings available	
Re	The lav	Completed						autop	rmed prior to death?	ompletion of cause of	
tal		ပိ	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes th (Check only o	2☑No 1☐Yes	2 1 No	
<u> </u>	S o D	.O.	examiner? 1 ☐ Yes 2 ☑ No	ospital:	2 ER/Outpatier	at 3 DOA Ot	har		dence 6 ☐Other (Spec	utv)	
Division of Vital Records,		T:U	27. Manner of Death	28a. Date of Injury (Month, Day Ye	28b. Time of Injury	f 28c. Inju			now injury occurred		
	Attending r death.	atlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	,	,]Yes 2 □ No				
Žį	or Atten efter deat Director:	Certification:	3 Suicide 4 Homicide 4 Homicide 288. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route City or Town, State)							ral Route Number.	
	To the Hospitel or At within 24 hours efter or To the Funeral Directompletely filled in by										
	To the Hospitel within 24 hours e To the Funeral I completely filled	edical	29a. Certifier 1 Certifying Physical Check only 2 Medical Examir	ner: On the basis of exa	the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. a basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)						
	thin 2 thin 2 or the	Мес	29b. Signature and title of certifier	and manner stated	•	29c. Licen	se number		29d. Date signed (Month	, Day, Year)	
	T with		N/A Q A			Dr	DS\$112		5/3/2-	7	
	~\		30. Name and address of person who op	mpleted cause of death	(Item 23a) (Type	Print)			- (1/0	1	
	51		Sharon M. Pan, MD		, 202, (1)50,				(
	Sta	ite	31. Date liled (Month, Day, Year)	32. Régistrar's	Signature	1					
	Registr	ar	MAY 0 9 20	JUI PORCER	IS for	00461					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMRID TTEM#20b perFH C867, 5/22/07 WS
State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Year MAY Zero /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NorthWest Hospital Baltimore Baltimore 6. Sex If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 ☐ F Yrs. 220-90-5995 Director 30 March10,1977 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 □ Yes 2 □ No Director RANDALLSTOWN MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 39 Western Win Circle 21244 U.S.A. Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. þ Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) it of Health and Mental Hygiene.
If item 27 Is marked other than '
or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Housekeeping
18. Mother's Name (First, Middle, Maiden Surname) 12±h Hospital 17. Father's Name (First, Middle, Last) Be ဂ Dennis Jefferson Shelly Lane 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ShellyJefferson/mother N.Curley St. Baltimore, Md 21214 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 16 14,2007 permit. Pages Department of I Important: If ite any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview CrematoryMay Baltimore, MD 21. Signature of Funeral Service License 22. Name and Address of Facility CALVIN 412 E. B. SCRUGGS PRESTON ST. FUNERAL HOME BALTIMORE, 21213 MD 23a. Part1. Enter the disease, or complications that calls the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the death certificate be executed burial Due to (or as a consequence of) attending physician for use as the buris Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year signed by the al 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐ Yes 2☐ No 9□Unknown 9 \ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown cate has been significant cannot be categorial beautiful to the categorian cannot be categorian beautiful to the categorian categori Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 1□ Yes 2 No Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 27, Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 1 □ Natural 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifler 29c. License number 29d. Date signed (Month, Day, Year) 7001

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division or Vital Records,

32. Registrar's S

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Day Year 1449 M BEATRICE JONES May 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Good Samaritan 400 Saltimore PITA 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday, 6. Sex **Funeral** 8. Date of Birth (Month, Day, Year) 1 M 2 F Days Hours 97 719 03 1686 Director FEB 12.1910 VIRGINIA Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at MD. N/ABALTIMORE 1 XiYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2744 21218 THE ALAMEDA USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married À 1 ☐ Yes 2√2 No Specify Specify: BLACK 3 Widowed 4 □ Divorced Year or Dates: Completed 16b. Kind of Business/Industry
US.TREASURY DEPT. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wi Department of Health and Mentat Hygien Important: If item 27 is marked other th any Injury or other traumatic event, the once. 12TH LABORER Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CHARLES H. LEE REBECCA HACHETTE ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5815 GLENKIRK COURT ELLA JEAN ADAMS (niece) BALTO, MD. 21239 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State OAKLAWN CEMETERY MAY 11,2007 BALTIMORE, MD. 4 ☐onation 5 ☐ Other (Specify) ignature of Funeral Service Licensee 22. Name and Address of Facility
CALVIN B. SCRUGGS FUNERAL HOME radene l 1412 F. PRESTON ST. BALTO, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ASCUD **Physician** /Medical Due to (or as a consequence of): Examiner ardjoningfort Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Live to (or as a consequence of): Examine law requires that the death certificate be executed attending physician and for use as the bunal-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ NO Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 | Yes 2 | No 3 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 No 1 | Probably 4 page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 2 No 2₽ No the Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 🗌 Yes 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deatl To the Funeral Director; filled in by the 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) -107 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lown 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1- State Registramend #1 Per Phy G868 6/07/07 Amend #1 Per Phy G868 6/07/07 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Lillan Lillian Keaton 2007 /Medical 2230 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Bon Secour Hospital Baltimore NA 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 ☐ M 2 🂢 F 92 Director 146-26-6678 Yrs. 3-29-1915 Ga Usual Residence of Decedent the Maryland 10a State 10c. City, Town or Location 10b. County 28a-f show 10d. Inside City Limits ral', or Items 23a or 28a-f ehov Examinar must be notified at Director Md. NA Baltimore YYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2029 Cecil Avenue 21218 USA Pages 1 and 2 should be filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 22 No If Yes, Give X Year or Dates: Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 3 € No Specify: Specify 3 ☐ Widowed 4 ☐ Divorced "natural" Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Schools other then " Elementary/Secondary (0-12) College (1-4or 5+) Custodial Baltimore City Pub 7th grade 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) and Mental marked Alexander Daniels Lois ၉ Butts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 l Joseph R. Keaton Son 2803 Southern Ave., Baltimore, Md. 21202 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of F Important: If ite eny Injury or oth pnce. 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park 5-10-07 Baltimore, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East 2 1101 E. North Ave., adh Wans Baltimore, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21202 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** locardia TINVTES /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physicien and s the buriat-transit law requires that the death certificate be executed Due to (or as a consequence of): Physiclan/Medical as attending for use as IF FEMALE 23c. If yes, outcome of pregnancy
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1 □ Yes 2 → No 23d. Date of delivery 3 Ectopic pregnancy Month 4☐Pregnant at time of death Day Year 5 Other (specify) P.O. been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐Unknown s certificete has b lirector, page 2 s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this To the Hospitel or Attending Phys within 24 hours efter death. To the Funeral Director: After this completely filled in by the funeral di 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending investigation 1 Natural 2 Accident 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0033330 2 rson who completed cause of death (Item 23a) (Type, Print) 3333 N. Lalvert 15 Balty, Md. 21218 32. Registrar's Signature 31. Date filed (Month, State Registrar

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To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the Medical Certification: To Be Completed by Physician/Medi	01	ne)		a	nd manner	stated.					uned at the time				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** 2007 Gabriel Kerrigan 6:30 Am May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** The Villa Baltimore Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🕅 F Months Days 213-66-5273 98 Director 1908 July 6, Ireland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ ... any injury or other traumatic every 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore Baltimore 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6806 Bellona Ave. 21212 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify þ Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5± nun/teacher education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Patrick Kerrigan Mary Coyne ٥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sr. Judith Waldt,MHSH/pers. rep. 1001 W. Joppa Rd. Towson, MD 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral Cemetery May 11,2007 Baltimore, Maryland 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, In
Raltimore, MD 2121 21. Signature of Funeral Service Licenses 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** con estimo disease or condition resulting in death) /Medical Due to (or as a of sequence of): Examiner Athero siler Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 9□Unknown Month Day Year 5 Other (specify) signed by the a 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∐ Yes 2 100 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, this ours after death.

neral Director: A
filled in by the fu within 24 hours a State

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 031861 30. Name and address of person who completed cayse of death (Item 23a) (Type, Print) Balt Mier-Door 32. Registrar's Signature 2/20 31. Date filed (Month, Day, Year) Registrar MAY 0 9 2007

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **6 Physician** 2007 1:34 A May William Edwin Leasure /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Baltimore Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1**X** M 2□ F Yrs. 295-24-7503 25, 1928 West Virginia Director 79 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c, City, Town or Location show 10b. County 10d. Inside City Limits a or 28a-f sho t be notified a 1 ☐ Yes 2 No Director Baltimore Nottingham Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 21236 U. S. A. 9007 Lodi Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 1950 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 No Specify: Specify: 2 3 N Widowed 4 □ Divorced Year or Dates: 1952 White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Social Security College (1-4or 5+) Administration Systems Analyst permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg Important: If Item 27 is marked other any Injury or other traumant. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Esther Hansen Charles Leasure ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 800 Diane Ct., Forest Hill, Maryland 21050 <u>Jeffrey Leasure (Son)</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/09/2007 Parkwood Cemetery Baltimore, Maryland 21. Signature of Funeral Service bicensee 22. Name and Address of Facility Schimunek Funeral Homes 9705 Belair Road, Baltimore, Maryland 21236 Approximate Interval Between Opset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final PNEUMONIA **Physician** aus disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 1,2000 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit PARKINSONS IS EASE Box 68760, Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 4□Pregnant at time of death 9□Unknown in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an 1□ Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? Certification: Division To the Hospital or Attending 5 Pending investigation 1 Tyes 2 No neral Director: / / filled in by the fi 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) ٥ Name and address of person who completed cause of death (Item 23a) (Type, Print) 555W 21304 D MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

	1 - State Registra
	1. Decedent's
ian	
	L V

Certificate of Death Name (First, Middle, Last)

2. Date of De	ath		3. Time of Death
Month	Day	Year	
May 3	2007		2.40 D

4c. County of Death

Harford

Physic /Medica Examiner

Vondell (nmn) Lindsay 4a. Fecility Name (If not institution, give street and number)

4b. City, Town, or Location of Death Joppa
If Under 1 Year If Under 24 Hrs.

Funeral

Director r then "netural", or iteme 23a or 28a-f ehow the Medical Examinar must be notified at Directo Funeral þ Completed permit. Pages 1 and 2 should be.
Department of Health and Mental h.
Important: if I fem 27 is markany injury or other-Be

> Physician /Medical Examiner

> > sicien and burial-transit

use as

certificete has been s rector, page 2 should

After

within 24 hours after death.

To the Funeral Director: A completely tilled in by the fu

Hospital

9

P.O. Box 68760.

Division of Vital Records,

altimore, Maryland 21215-0036

1008 Magnolia Road 5. Social Security Number 6. Sex 215-28-2186 Usual Residence of Decedent 10a, State 10b. County Maryland Harford 10e, Street and Number

11. Marital Status

10c. City, Town or Location Joppa 10f. Zin Code

Yrs.

7. Age (In yrs. last birthday)

80

Days

8. Date of Birth (Month, Dey, Year) Jan. 4, 1927

 Birthplace (State or Foreign Country) Georgia

10d. Inside City Limits

1 ☐ Yes 2 🛣 No

10g. Citizen of What Country?

Specify:

USA

1008 Magnolia Road

12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:

1 □ M 2 🔀 F

21085 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Race - American Indian, Black, White, etc.

15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

1 ☐ Yes 2 No

White 16b. Kind of Business/Industry

Elementary/Secondary (0-12) 8 17. Father's Name (First, Middle, Last)

1 ☐ Never Married 2 X Married

3 ☐ Widowed 4 ☐ Divorced

Homemaker

Own Home 18. Mother's Name (First, Middle, Maiden Sumame)

James Washington Todd

Lilly Corine Kicklighter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19a Informant's Name/Relationship (Type, Print) Charles R. Lindsay / Husband

1008 Magnolia Road, Joppa, Maryland 21085 20b. Place of Disposition (Name of cemetery, crematory or other place) Date

20c. Location - City or Town, State

20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

Highview Memorial Gran 5-8-07

Fallston, Maryland

21. Si peture of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line.

22. Name and Address of Facility
McComas Funeral Home, P.A.

1317 Cokesbury Road, Abingdon, Maryland 21009 Approximate Interval Between

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Examiner

Congestive	heart
Due to (or as a consequence of Atvial	

brillation

Due to (or as a consequence of):

Due to (or as a consequence of):

IF FEMALE:

Physician/Medicai

Be Completed by

Certification: To

Medicai

23b. Was decedent pregnant

in the past 12 months?

23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetel death 4☐Pregnant at time of death

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

24a. Was an

1 Yes 2 No 3 Probably 4 Unknown

autopsy performed 1 Yes 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 Yes 2 No

27. Manner of Death 1. Natural 2 Accident

3 Suicide

4 Homicide

5 Pending investigation 6 ☐ Could not be determined

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2,2 No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29d. Date signed (Month, Dey, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

038933 /MD 104 Phontree Rd. Sie 102

31. Date filed (Month, Day, Year)

Luight MD 32. Angistrar's Signature

State Registrar

10

DHMH 17 Rev 1/2001

ORIGINAL

07-03314	
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-03314 hristopher Min	Lar	Please Type or Print in Bla ppe State of Maryland /				_						
		1- For State Registrar	•	te of Death	oritai i i	_	. No.	007 149				
Physici ledical Exam		Decedent's Name (First, Middle,Last)	la			2. Date of Death	Day Year	3. Time of Death 0437 hrs				
		4a. Facility Name (if not institution, give street and number) Outer Loop 695 & Frederick Road		4b. City, Town, or Lo Baltimore	ocation of Death		4c. County of I Baltimore					
Funeral Director		5. Social Security Number 6. Sex 7. Age 213-92-9548 1 Number 38	(In yrs. last birth	day) If Under 1 Year Months Days Yrs.	If Under 24Hrs. Hours Min.	8. Date of Birth	` 15	Birthplace (State or or oreign Country) Korea				
any		Usual Residence of Decedent 10a. State 10b. County	I0c. City, Town o	r Location				10d. Inside City Limits				
* .	or	MD Howard		cott City				1 Yes 2 X No				
the Mary is or 28a- etified at	Director	10e Street and Number 9744 Riverside Circle		10f. Zip Code	21042	100	. Citizen of What USA	Country?				
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. The strict of Health and Mental Hygiene. The strict of Health and winter than "natural", or items 23a or 28a-f she wit. If item 27 is marked other than "natural", or items 23a or 28a-f she we there traumatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 X Never Married 2 Married Armed Forces? 1 X Yes 2	ever in U.S.	13. Was Decedent of Hispa If Yes, specify Cuban, I	Mexican, Puerto		White, etc. Korean					
ırs afte ural", miner	ρ	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade company)	pleted) 16a, D	1 Yes 2 X No ecedent's Usual Occupatio		ork done	Specify: 16b. Kind of Business/Industry					
5 72 hou n "nat	Completed	Elementary/Secondary (0-12) College (1-4 or 5-	di	uring most of working life. D								
21215-0036 uld be filed within 72 Mental Hygiene. marked other than '	duc	12		carpenter			constru	ction				
21215-003 Juld be filed within I Mental Hygiene. I marked other the ceyent, the Media	Be C	17. Father's Name (First, Middle, Last) Donald R. Lampe		18	3.Mother's Name Mary	(First, Middle, Markette) (Tanne	,					
212 212 213 21 Ment mark ic ever	To B	19a. Informant's Name/Relationship (Type, Print)	19b.	Mailing Address (Street a				State, Zip Code)				
MD d 2 sho lth and n 27 is		Donald R. Lampe, father		744 Riversid								
Baltimore, MD 2 permit. Pages 1 and 2 shoul Department of Health and M Important: If item 27 is minjury or other traumatic of		20a. Method of Disposition 1 Surial 2 Cremation 3 Removal from State	e cremator	Disposition (Name of cemery or other place)	,	Date	20c. Location - Ci	ty or Town, State				
Baltimore, permit. Pages I an Department of He Important; If ite		4 Donation 5 Other Specify:	Dulane	ey Valley Mer			Timoniu					
Balt permit Depart Impor injury		21. Signature of Funeral Service Licensee		22. Name and Address of	atonsvil	le. Inc	. 1630 E	dmondson Ave. 11e Md 2122				
Physician		23a. Part 1. Enter the disease, or complications that caused the	ne death. Do not	enter the mode of dying, su	uch as cardiac or	respiratory arres	Catonsvi t, shock, or heart	Approximate Interval				
/Medical xaminer		failure. List only one cause on each line. Immediate Cause (Final disease a. Multiple Injuries a	and Compres	ssional Asphyxia				Between Onset and Death				
xammer		or condition resulting in death) Due to (or as a consec										
	er	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):										
10	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated C. Due to (or as a consequence of):										
cuted and transit		events resulting in death) Last Due to (or as a consect d.	quence or):									
e exe cian a	Physician/Medical	UNPENDED AMENDED				-						
Box 68760, s death certificate be the attending physici ed for use as the buri	/Me	IF FEMALE: 23b. Was decedent pregnant in the	e of pregnancy				23d. Date of de	•				
x 68 h certif ending use as	cian	past 12 months? 4 Pregnant at ti	me of death 5	Fetal death 3 Other (Specify)	Ectopic pregnar	ncy	Month	Day Year				
	hysi	1 Yes 2 No 9 Unknown g Unknown										
ecords, P.O. E he law requires that the c te has been signed by the tge 2 should be detached	by	Part II. Other significant conditions contributing to death	but not resulting	in the underlying cause giv	ren in Part I.		acco use contribu 2 ✓ No 3	te to the cause of death? Probably 4 Unknown				
Division of Vital Records, sale Attending Physician: The law requires all or earth. In Director After this certificate has been seled in by the funeral director, page 2 should t	Completed					24a. Was ar		re autopsy findings available r to completion of cause of				
Reco The law cate has	omp					perform	ied? dea					
Vital Recysion: The his certificate director, page	Be C	25. Was case referred to medical			of Death (Check o							
F Vit	ToE	examiner? 1 V Yes 2 No Hospital: 1 Inpatien					esidence 6 🗸	Other: Scene				
n of rding Pt. h.: After a funcral	on:	27. Manner of Death 28a. Date of Injury 1 Natural 5 Pending May 1, 2007	(286. Ti 0155	me of Injury 28c. Injury		^{28d.} Describe ho Driver auto a	w injury occurred uto collision					
ivisior or Attend after death Director:	icati	2 Accident Investigation 28e. Place of Inju	rv - At home, fan	m, street, factory, office buil		28f. Location (St	reet and Number	or Rural Route Number, City				
Div iital or urs afte ral Di	Certification:	3 Suicide 6 Could not be determined (Specify) Majo			9, 5.6.	or Town, Sta Outerloop 695	ite) & Frederick Rd.	Baltimore, MD				
DIVI To the Hospital or within 24 hours after To the Funeral Dir	Medical C	29a. Certifier 1 Certifying Physician: To the best of my one) 2 Medical Examiner: On the basis of exam			and place, and	due to the cause	(s) and manner as	stated.				
To with	Mec	and manner stated. 29b. Signature and title of certifier										
		Myling Brassell, ME	}_	O.C.M	.E.		May 1, 2007					
10		30. Name and address of person who completed cause of de Melissa Brassell, MD Assistant Medical I		111 Penn Street, Ba	Itimore, MD 2	21201						
Si Regis	tate trar	31. Date filed (Month, Day, Year) 2. Registrar's		reli	,							
	1	ITICAL V. V. COOL PARCES										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. C. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year LAINA LEVETTE MILES 12107AM 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death UNION MEMORIAL HOSPITAL N/A BALTIMORE CITY Social Security Number If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours Min. 1 □ M 2 X F 214-68-4350 50 09/12/1956 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits BALTIMORE PIKESVILLE 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3714 PINELEA ROAD 21208 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 □ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MAIL CARRIER US POSTAL SERVICE 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CHARLES E WILSON LILLIAN L ALLEN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ERNEST MILES / HUSBAND 3714 PINELEA ROAD, PIKESVILLE, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State □ Cremation 5 □ Other (Specify) KING MEM. 5/12/07 PARK WINDSOR MILL, MD 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 21. Signature of Funeral Service License 4600 LIBERTY HEIGHTS AV, BALTIMORE, MD ler the disease, or complications that caused the teath. Do not enter the mode of dying, such as cardiac or respiratory arrest, hear failure. List only one cause on each line. Approximate Interval Between Onset and Death immedia - ause (Final diseas r condition resulting in death) 41MONEY Due to (or as a con equence of) DENTERS10. Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a a consequence of) Due to (or as a consequence of) 23c. if yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 □Ectopic pregnancy Year

Physician /Medical **Examiner**

certificate be executed

Box 68760.

Division or Vital Records, P.O.

Hospital or Attending

To the

within 24 hours aft

To the Funeral Di

completely filled in

Medical

State Registrar

Physician

/Medical

Examiner

MD

Funeral

Director

"natural", or items 23a or 28a-f show dical Examiner must be notified at

event, the Medical

than

marked other alth and Mental Hv

permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any Injury or other traumatic ev

72 hours after

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

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bunial-transit and attending physician for use as the buria the Š pe certificate this

Examine Physician/Medical þ Completed Be P in by the funeral after death. Certification:

IF FEMALE Part II. Oth

1 Yes

27. Manner of Death

1 Natural

2 Accident 3 Suicide

4 | Homicide

29a. Certifier

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 Unknown

25. Was case referred to medical examiner?

2 No

4□Pregnant at time of death 9 I Inknown

5 Other (specify)

Month

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No

2 No

er significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobac	co use con	tribute to the cau	se of death?
	1 ☐ Yes	2□ No	3 ☐ Probably	4 Donknown

26. Place of Death Check onli one

Hospital: 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 5 Pending investigation 6 ☐ Could not be

and manner stated.

28c. Injury at Work? 28b. Time of Injury

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

2 🗆 No

24a. Was an

1X Yes

1 ☐ Yes 2 ☐ No

29c. License number

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

9b.	Signatu	e and title of certifier	_	
		tiler.	Un	MO

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			1 - For State Registrar	State of M	arylan				lealth an Death	d Menta		giene	107	149/1	
i i	Dhyaiai		1. Decedent's Name (First, Middle, Las	st)							ite of Dea	ath Day	Year	3. Time of Death	
	Physici /Medic		Mercedes Miner								1,	2007		5:30 A ^M	
	Examir		4a. Facility Name (If not institution, give	street and number)			4b. City	, Town, or	Location of E	Death		4c. Cour	nty of Death		
			333 Sullivan Driv		Abingdon 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8						Harford Date of Birth 9. Birthplace (State				
	Funeral Director			ex □M 2 X 1F	88 (In yrs.)	iast birthday) Yrs.	Months			Min. (M	onth, Day	η y, <i>Υθαί)</i> 5, 1919	Coul	olace (State or Foreign ntry) vland	
***.	ó,		Usual Residence of Decedent							Apı		, 1919	Hal	yranu	
	how		10a. State 10b. County		10c. Cit	y, Town or Lo	cation						1	10d. Inside City Limits	
	e Ma	cto	Maryland Harfor	d	Abi	ngdon								1 ☐ Yes 2X No	
	hours after death with the Maryland tural, or Items 23e or 28e-f show al Examiner must be netitied at	Directo	10e. Street and Number				10f. Z	ip Code				10g. Citizen o	f What Cou	ntry?	
	s 23s	rai	333 Sullivan Driv	e 12. Was Decedent	Francia III	6 101	Man Dan	2100		2 (CX V		U.S.A.	200 America	and toding	
	Item Item	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?	•	.5.	was Dec	ecify Cuba	ispanic Origin In, Mexican, P	uerto Rican,	es or No-	14. N	ace - Amendack, White,	American Indian, Vhite, etc.	
5	ours after deal ral', or Items ? Extruiter ou	by F	3 ₩ Widowed 4 Divorced	If Yes, Give Year or Dates:	110		1 🗆 Yes	2 X) No	Specify:			Spec	cify: Wh	nite	
2-003p	72 hours 'natural', dical Ex	ted	15. Decedent's Ed	lucation		16a. Dece	dent's Us	ual Occup	ation	fandrima		16b. Kind of	Business/In	dustry	
2	within 7 ene. than "r	aple.	(Specify only highest gra	College (1-4or	5+)	life.	DO NOT	use retired	during most of f)	i working					
7	ygien ygien t. th	Completed	8			Sales	woma	n			-		osmetics		
	tal H d oth	Be	17. Father's Name (First, Middle, Last)										den Sumame)		
ire, Maryis s 1 and 2 should f Health and Mer ltem 27 is marke other traumatic	ဥ	John S. Snyder Marie G. Schmid 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, C										. 0-1- 7	0-1-1		
	d 2 st th and 7 is r traur				·)		•							Code)	
	1 an Heal tem 2		Lorraine Connolly 20a. Method of Disposition	n 20b. Place of Disposition (Name of Date 20c. Location - City or Tow										own, State	
و			1 🔀 Burial 2 🗆 Cremation 3 🗆				•			** 2 2	007				
Baltimo permit Page Department of Importent: it any injury or	arite Paritime corten		4 Donation 5 Other (Specify) Gardens of Faith May 3, 2007 Baltimore, May 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home												
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B	7.		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause	d the death									Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	Voi	A / .	1100 +	Nica							Onset and Death	
	/Medical		resulting in death)	Due to (or as	a conseq	uence of):	WY	1/2						L.	
	Examiner		Sequentially list conditions. b. Wironey Authy Olycon										10		
	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	uence of):	(1.	, h					lot	
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×	eath certifica attending ph for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome								23d. E	Date of delive	erv	
ň	death e atte d for	Icia	in the past 12 months?	1□Live birth 4□Pregnant a			JEctopic Other (s	pregnancy specify)					Month	Day Year	
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	The laste has page	Ь								1[perfo	rmed? 20 No	death?	2 □ No	
VITAI H	Physician: The lav this certificate has rai director, page 2	Be	25. Was case referred to medical examiner?	11					26. Place of	Death (Che	ck only o	ne)			
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	ding f h. After funer	lo l	27. Man⊓er of Death 1 X Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year)	28b. Time of Injury	м	28c. Injun Worl	yat k? Yes 2 □ No		escribe h	low injury occi	urred		
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2	after Dire	Certification:	4 ☐ Homicide determined	building, el	c. (Specify	y)	001, 10010	17, 011100				m, State)		ar rougo rumbor,	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer		29a. Certifier 1X Certifying Ph	ysician: To the best	of my kno	wledge, death	n occurre	d at the tin	ne, date and p	place, and du	e to the	cause(s) and r	manner as s	tated.	
	n 24 ł n 24 ł he Fu	edical	(Check only 2 Medical Examone)	niner: On the basis of and manner st	f examina	tion and/or in	vestigatio	n, in my o	pinion, death o	occurred at ti	he time, (date and place	e, and due to	o the cause(s)	
	To tl withi To tl	ž	29b. Signature and title of certifier				25	9c. Licensi				29d. Date sign	ned (Month,	Day, Year)	
			Highelf. And	du				44	0583			5/4/0	7		
			30. Name and address of person who	completed cause of o	death (Item	1 23a) (Type,	Print)						-		

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienen Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Herman Mueller, Jr. May 5, 2007 12:42 P 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death 2718 Fallsbrook Manor Drive Fallston Harford If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1X M 2 □ F 77 219-28-0015 March 8, 1930 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2X No Maryland Harford Fallston 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 2718 Fallsbrook Manor Drive 21047 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Y⊒Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 2 No Specify: White 1 ☐ Yes Ž☐ No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Private Contractor Home Building 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Herman Mueller, Sr. Thelma Emmonds 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sherri Glack (Daughter) 2718 Fallsbrook Manor Drive Fallston, MD 21047 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley 5/9/2007 Baltimore, Maryland 22. Name and Address of Facility Schimunek Funeral Home of Bel Air 21. Signature of Forneral Service Li Inc. 610 W. MacPhail Rd. Bel Air, MD 21014 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) NE TASTA Due to (or as a consequence of): Sequentially list conditions, if arry, leading to limite liste cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dusity (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy 4 Pregnant at time of death 9 Unknown Day Year 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🗷 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be i

of Health and Mental Hygiene.

permit. Pages 1
Department of F
Important: If ite
any injury or ot

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

Division or Vital Records,

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Director

Funeral

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Completed

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Examine Physician/Medical <u>Ş</u> Completed

burial-transi attending physician and for use as the burial-trar signed by the at d be detached for Be this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral of Certification:

IF FEMALE:
23b. Was decedent pregnant
in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown

1 ☐ Yes 2 ☐ No

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

4 Homicide

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

26. Place of Death (Check only one)

25. Was case referred to medical examiner?

6 ☐ Could not be

determined

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day 5 ☐ Pending investigation

28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Year)

1 Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certific of death (Item 23a) (Type, Print)

State Registrar

6

Medical

31. Date filed (Month, Day,

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 2007 May 6, Landon Ray McCourry 11:20 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 16 Blister Street Middle River Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08/14/1914 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days North Carolina 10 M 2 □ F 245-14-6254 92 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits the Medical Examiner must be notified at 1 ☐ Yes 2XXNo Director Maryland Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21220 16 Blister Street U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ②☑•No If Yes, Give 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: þ 3XXWidowed 4 ☐ Divorced Year or Dates: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Assembler General Motors Corp. other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William M. McCourry Eva Renfro Beaver 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau Kelly Tingler (Granddaughter) 16 Blister Street, Baltimore, Maryland 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gard May 10,2007 Baltimore, Maryland 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Eacility
Bruzdzinski Funeral Home, P.A 21. Signature of Funeral Service Licenses 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediat Cruse (Final **Physician** eun disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy for in the past 12 months? Month Dav 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 1 Tyes 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2 s autopsy performed? 1□ Yes 2-1No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

State

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30. Name and address of person who completed c use if

2007

eath (Item 23a) (Type, Print)

Ma

3 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** Melton MAY Willie 2007 21 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 50 BALTI MORE d41e ose 1405 IARE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Security Number **Funeral** 1**X** M 2□ F Days Months Hours 70 246-52-1748 **Director** 26 36 05 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ms 23a or 28a-f show must be notified at 1 XIYes 2 □ No Director Baltimore MD NA the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with U.S.A. Funeral 5255 Cedgate Road 21206 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married ò 1 □ Yes 2√2 No Specify: Specify: Black Completed by 3 ☐ Widowed X ☐ Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 7 is marked other than "natu traumatic event, the Medical 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Co. School System Custodian 10th grade na 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sarah Morgan Robert Melton P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trai once. 611 Queensgate Road, Baltimore, Md 21229 Lisa Gross-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State King Memorial Park 5/5/07 4 ☐ Donation 5 ☐ Other (Specify) |Randallstown, Md 21 Signature of Funeral Service Licensee March F/H West 212115 4300 Wabash Ave, Baltimore, Md Approximate Interval Between Onset and Death 3a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. mmedia e Cause (Final tisease or condition r sulti g in death) **Physician** /Medical Due to (or as a consequence of): Examiner Wheles Melli Sequentially list conditions, if any, leading to immediate cause (Disease or injury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed FAILUR KeNAI that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 ☐ Other (specify) 4 ☐ Pregnant at time of death 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 □ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No Director: / 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours at To the Funeral L To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) H45300 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BLACKBURN York

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31. Date filed (Month,

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Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** DS 06 6:04 2007 Joseph Thomas McLaughlin /Medical 4a_Facility Name (If not institution, give street and number) 4c. County of Death Town, or Location of Death Examiner Franklin Square Hospital Battimore sedale Year If Under 24 Hrs. . Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours 1**X** M 2□ F Director 72 12/07/1934 Maryland 212-32-3638 Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits show must be notified at 1 ☐ Yes 2 No Director MD Baltimore Baltimore 28a-f 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 9002 Fieldchat Road 21236 U.S.A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. traumatic event, the Medical Examiner 1 XYes 2 □ No If Yes, Give 1957–1959 Year or Dates. 1 Never Married 2 Married 1 ☐ Yes 2X No Be Completed by 3 Widowed 4 Divorced White Baltimore, Maryland 21215-00 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) al Hygiene. Computer Programmer 12 Steel Industry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James McLaughlin Margaret Toal 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) perr it. Pages 1 and Deportment of Health Important: If item 27 any injury or other troons. Susan I. McLaughlin (wife) 9002 Fieldchat Road - Baltimore, Maryland 21236 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Highview Mem. Gdns. 05/10/2007 | Fallston, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, Maryland 21087 assala 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** months /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): P.O. Box 68760, Physician/Medical the IF FEMALE use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 ☐ Unknown ate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an was autopsy performed? Yes 2 No death? 1 ☐ Yes 2∏ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural Hospital or Attending Pl 24 hours after death. Funeral Director: After the 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MR

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Registrar

State

Name and address of person, who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Vay 3 No 11:50AM *₩*7 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Shady Grove Adventist Hospital Montgomery Rockville If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Min. 1□M 200 F 60 219-48-3905 WASHINGTON D.C. 03/01/1947 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 22 No Director Rockville MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 20853-United States 15804 Thistlebridge Dr. 2 should be filed within 72 hours after death v and Mental Hygiene. is marked other than "natural", or items 23s by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2X If Yes, Give Year or Dates: 200 No 1 Never Married Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry traumatic event, the Medical Federal Government Elementary/Secondary (0-12) College (1-4or 5+) Manager / Analyst 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and 2 should be ealth and Mental Thelma Morgan Edmund King 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) 15804 Thistlebridge Dr. Rockville, MD 20853-Department of Health a Important: If item 27 is any injury or other trains William A. Michie/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition May 8 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Beltsville, Maryland Chesapeake Crematory Inc.2007 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Rapp Funeral & Cremation Services 21. Signature of Funeral Service Sty Kollmann 933 Gist Ave. Silver Spring, Maryland 20910-Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, it any, isating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) burial-1 physician the burial P.O. Box 68760 Physician/Medical attending ph for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Year 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? Division or Vital Records, Be Completed by 2 No 1 Yes 3 ☐ Probably 4 ☐ Unknown as been signal 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy certificate ha perform 2 No 20 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient ဥ 1 Yes No 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death.

I Director: A
d in by the fu 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D completely filled is Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 1/2001

State

NIOHI

31. Date filed (Month, Day, Year)

1901 Medical Center Dr. ve, Rockville, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

SINGH NIKHANI, MD

			1 - For State Registrar		Marylan		artment of rtificate o				ene () () 7	14977			
	Physici	an	Decedent's Name (First, Middle,	Last)						Date of Death	Day Year	3. Time of Death			
	/Medi		JUNE L.	MOLDOWS						Month	4 200	7 10.41 PM			
	Examir	er	4a. Facility Name (If not institution,		ber)		4b. City, Town		th						
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			Usual Residence of Decedent						00	ine I,	1929 Mar	yland			
	yland		10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside City Limits			
	e-fs	cto	MD Mont	tgomery	E	Burtons	sville					1 ☐ Yes 2 No			
	ith th	Director	10e. Street and Number				10f. Zip Code	9		10g	g. Citizen of What C	ountry?			
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	72 hours after death with the Maryland 'natural', or Items 23a or 28e-f show dieni Exactinat must be troffled at	Funeral	11. Marital Status	12. Was Deced Armed Ford		S. 13.	Was Decedent of f Yes, specify C	of Hispanic Ori uban, Mexicar	igin? (Specify	Yes or No-	14. Race - American Indian, Black, White, etc.				
36	s afte		1 Never Married 2 Marrie	If Yes, Give			1□Yes 2⊠N			, , , ,	0#				
Ö	hour tural'	Completed by	3 ₩ Widowed 4 □ Divorced	Year or Dat	les:	100 0					***	nite			
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an	lid be lental rked ic ev	To B	Howard Leslie Wo	otten. Si	^_			Emma	Carri	e Snyde	or				
Maryland 21215-0036	should be and Mental s marked o umatic eve		19a. Informant's Name/Relationship			19b. Mailir	g Address (Stre				City or Town, State,	Zip Code)			
	and 2 ealth a n 27 ls		William H. Ammar	nn/Son		4330	Sandy S	pring	Road,	Burtons	sville, MI	20866			
Baltimore,	of He Item		20a. Method of Disposition		1 -	lace of Dispo	sition (Name of natory or other p		Date		c. Location - City or				
Ĕ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-1 show any injury or other traumatic event, the Medical Examinar must be redified at once.		1 M Burial 2 ☐ Cremation 3 - `4 ☐ Donation 5 ☐ Other (Spe		late				5/9/20	07 Br	centwood,	MD			
aĦ	permit. Departm Importa any inju	'4 Donation 5 Other (Specify) 21. Signature of Funeral Servic Cicen se 22. Name and Address of Facility Donaldson Funeral Hor													
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	Pnysician /Medical Examiner	resulting in death) Due to (or as a consequence of):									t,	Approximate Interval Between Onset and Death			
8760,	icate be executed physician and s the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	r as a consequ										
.O. Box 6	The law requires that the death certific tte has been signed by the attending p bage 2 should be detached for use as	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		h 2 ∏Fetal nt at time of de	death 3	Ectopic pregnar Other (specify)				23d. Date of de Month	ivery Day Year			
Records, P.	quires than a signed l	d by P	Part II. Other significant conditions CHRONIC K	contributing to deal	th but not resu	ilting in the ur	iderlying cause o	given in Part I.				othe cause of death?			
00	s been si	olete	DIABETES N	ELLITA	15					24a. Was an	24b. Were au	itopsy findings available			
	The lav te has age 2	mo	MYELD NUCPI	ARIA						autopsy	d? prior to death?	completion of cause of			
Viital		0	25. Was case referred to medical	7) 3) 17			-	26 Place		1□ Yes 2□ neck only one)	No 1 ☐ Yes	2 D No			
>	W 0 75	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inp	patient 2021	R/Outpatient	3 □ DOA C	NAL -			e 6 ☐ Other (Spe	cufu)			
Division of	ing Ph After th funeral	atlon: 1	27. Manner of Death Natural 5 Pending Accident investigat	28a, Date of (Month,		28b. Time of Injury	28c. inj		28d.		injury occurred	ony)			
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	To the Hospitel or within 24 hours affe to the Funeral Dir completely filled in	Medical	one) 2 Medical Ex	Physician: To the be aminer: On the bas and manne	is of examinat	vledge, death ion and/or inv	estigation, in my	opinion, deal	d place, and o	t the time, date	and place, and due	to the cause(s)			
	on With	~	29b. Signature and title of certifier	. Va	llia	w'		28191		29d.	Date signed (Mont)	h, Day, Year)			
-	2	-	30. Name and address of person wh	KHANI, O	2835	Smil	7+ Ave	= Su	ITE 22	3, B	ACTO MI)	21209			
	Sta Registra		31. Date filed (Month, Day, Year) MAY 0 9 2	2007 3 Reg	ristrar's Signar	ure Arc	de								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** May 2007 8:20 P^M Don Streper Mackey 4, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 608 Priestford Road Churchville Harford If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours **™** M 2□ F Yrs. 217-12-8997 82 Aug. 8, 1924 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. Count 10c. City, Town or Location r than "natural", or items 23s or 28s-f show the Medical Exeminer must be natified at 1 ☐ Yes 2X No Director Maryland Harford Churchville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 608 Priestford Road 21028 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ es 2 □ No If Yes, Give Year or Dates: ₩₩∏ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 TvNo Specify: by 3 Widowed 4 Divorced WWII White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Engineering Technician 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fil iment of Health and Mental H tant: If item 27 is marked oil Be Samuel Streper Mackey Martha Reed Watson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 608 Priestford Road, Churchville, Maryland 21028 Eula Mackey/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition permit. Pages 1 Depertment of H Important: If Its any injury or ot once. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Churchville, Maryland 5-9-07 Churchville Pres. Ch. 21. Signature of Funeral Service Licensee McComas Funeral Home, P.A. Kussell 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MO disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner eN me Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine attending physicien end for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ed by the a detached to 1 ☐ Yes 2 ☐ No 9 Unknown 9 ☐ Unknown s been signed b 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No this certificate has ral director, page 2 1 Yes 200 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 2 1 Yes 2 KINO 1 Inpatient 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Injury 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide

requires that the death certificate be executed P.O. Box 68760 Records. Division of Vital or Attending Physician:

with the Manyland

r death

filed within 72 hours after

Baltimore. Maryland 21215-0036

I

State Registrar

29a. Certifier

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) MAY 0 9 2007 520 Upper Chesopeake #E. Registrar's Signature

1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

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Funeral Director			M 2₽F /		Yrs.	Months Days		Min. (/	ate of Birth Month, Day, Yea		irthplace (State or Foreign Country)		
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nylan how		10a. State 10b. County		10c. City, Tow	n or Lo	cation			10d. Inside City				
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2 should I and Meni is marke	-	19a. Informant's Name/Relationship (7	ype, Print)	196	Mailin	g Address (Stree	l			or Town, State.	Zip Code)		
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To til To til comp	ž	29b. Signature and title of pertifier				29c. Licens	e number		29d. D	ate signed (Mon	th, Day, Year)		
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)		ALI RAHIN	MIANIN	10 7	50	SUR	RAT	TS ROA	4120	2 Cri	NTON 207		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Registrar

State of Maryland / Department of Health and Mental Hygiene Cortificate (Cortificate dent's Name (First, Middle, Last) 2. Date of Death **Physician** 1207 AM Joseph Andrew Major 04 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner AGNES HOSPITAL BALTIMORE SAINT 1 Year If Under 24 Hrs.

Days Hours Min. 8. Date of Birth (Month, Day, Year 9. Birthplace (State or Foreign Country)
Maryland 7. Age (In yrs. last birthday, **Funeral** 1 XM 2 ☐ F 88 Director 217-05-5315 Feb. 6, 1919 Usual Residence of Decedent death with the Maryland 10c, City, Town or Location 10b. County 10d. Inside City Limits ms 23a or 28a-f show must be notified at 1 ☐ Yes 21 No Director Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 709 Crosby Road 21228 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M/Yes = 10 M/Yes If Yes, Give Year or Dates: 1944-46 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2X No þ Specify: Specify: White 3 Widowed 4 □ Divorced "natural"; Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Master Electrician Electrical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked John Edmund Major Hilda Schalitzky ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 i JoAnn Hayden - Daughter 16123 Dark Hollow Road; Upperco, MD 21155 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages
Department of t
Important: If Ite
any injury or o'
once, 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5-7-2007 Druid Ridge Cemetery : Pikesville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sterling-Ashton-Schwab-Witzke Funeral Home of Catonsville, Inc. 1030 Edmondson Avenue; Catonsville, MD 21228 Standa Lemme 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) NEUMONIA **Physician** WEEK /Medical Due to (or as a consequence of): Examiner AGE 111-B NON SMALL CELL LUNG CANCER frany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed SEVERE AORTIC STENOSIS Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy perform Vital Hospital or Attending Physician: 44 hours after death. Funeral Director; After this certificately filled in by the funeral director, p. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA ō 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Natural 2 ☐ Accident (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide on the Funeral Decompletely filler Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month, Day, Year) Clu MAY, 05, 2007 209 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

12+1

MUDDASSIR S 31. Date filed (Month, Day, Year) MAY 0 9 2007 Registrar

SANA

900-5 CATON 32. Registrar's Signature

AVENUE, BALTIMORE, MD 21229

			1 - State of Man		rtment of Health an tificate of Death		ene 3. No. 007	1,981		
	Physici /Medic		1. Decedent's Name (First, Middle, Last) LEO F. MARTIN SR.			2. Date of Death Month MAY	Day Year	3. Time of Death		
	Examir	er	4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center		4b. City, Town, or Location of C Annapolis	eath	4c. County of Death Anne Arundel			
*	Funeral Director			In yrs. last birthday) Yrs.	If Under 1 Year II Under 24 Months Days Hours	Hrs. 8. Date of Birth (Month, Day, Nov. 23	(ear) 9. Birth Cou.	place (State or Foreign intry) ryland		
115-	yland wow		Usual Residence of Decedent 10a. State 10b. County 1	Oc. City, Town or Lo	cation			10d. Inside City Limits		
	Ba-f st	Director	Maryland N/A	Ba1	timore			1 V Yes 2 No		
	with the	Dire	10e. Street and Number 1533 Covington Street		10f. Zip Code 21230	10	g. Citizen of What Cou U.S.A.	intry?		
980	hours after death with the Maryland turel', or Items 23s or 28s-f show al Exercinet frout be notified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Mill Widowed 4 Divorced 1. Was Decedent Ever Armed Forces? 1. Decedent Ever Armed Forces. 1. Decedent Ever Armed Forces. 1. Decedent Ever Armed Forces. 1. Decedent Ever Armed Forces. 1. Decedent Ever Armed Forces. 1. Decedent Ever Armed Forces. 1. Decedent Ever Armed Forces. 1. Decedent Ever Armed Forces. 1. Decedent Ever Armed Forces. 1. Decedent Ever Armed Forces. 1. Decedent Ever Armed Forces. 1. Decedent Ever Armed Forces. 1. Decedent Ever Armed Forces. 1. Decedent Ever Armed Forces. 1. Decedent Ever Armed Forces. 1. Decedent Ever Armed Forces. 1. Decedent Ever		Vas Decedent of Hispanic Origin Yes, specify Cuban, Mexican, P Yes 2 No Specify:	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Amer Black, White Spewhite			
Maryland 21215-0036	within 72 ane. than "net	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give life. L	ent's Usual Occupation kind of work done during most of OO NOT use retired) er Carrier	working	.S. Postal	ŕ		
d 2	filled Hygi ther	Be Cc	17. Father's Name (First, Middle, Last)	Lett		Name (First, Middle, Ma		Delvice		
ylaı		To	Leo J. Martin	200 100 110	Rose					
Mai	nd 2 :		19a. Informant's Name/Relationship (Type, Print) Leo F. Martin Jr. (Son)		g Address <i>(Street and Number</i> o abbs Creek Road					
Baltimore,	permit. Pages 1 ar Department of Hea Importent; If Item: eny Injury or othe gnce.			20b. Place of Dispo cemetery, cren		Date 26	oc. Location - City or T len Burnie	own, State		
Balt	permit. Departr Importe eny Inju		21. Signature of Funeral Service Licen	Mc Mc	Name and Address of Facility Cully—Polyniak	130 E. For Funeral Hor	rt Avenue, me P.A. Ma:	Baltimore ryland 21230		
			23a. Denti. Enter the disease, or complications that caused the mock, or heart failure. List only one cause on each line.	e death. Do not ente	er the mode of dying, such as car	diac or respiratory arres	t,	Approximate Interval Between Onset and Death		
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. ACUTE Due to (or as a condition resulting in death)	E MYOCA	ARDIAL INF	ARCTION		Oliset and Death		
	Examiner		Sequentially list conditions, b.							
7	petu d ansit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
8760,	cate be executed physicien and the burial-transit	dical Exa	resulting in death) Last	consequence of):						
9	rtificati ing phy e as the	Medic	IF FEMALE:							
P.O. Box	The law requires that the death certificate tite has been signed by the attending physoage 2 should be detached for use as the	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of delik Month	rery Day Year		
	w requires that the bean signed by should be detact	by	Part II. Other significant conditions contributing to death but of END STAGE RENAU D		iderlying cause given in Part I.	23e. Did toba	cco use contribute to			
al Records,		Completed				24a. Was an autopsy perform	prior to c	opsy lindings available or cause of No		
Vital	Physician: Trust certificated director, p	o Be	25. Was case referred to medical examiner? 1 Yes	✓ FR/Outpatien		Death Check only one		£ 1		
Division of	ding After fune	ition: To	27. Manner of Leath 1 Natural 5 Pending 2 Accident Investigation 28a. Date of Injury (Month, Day Y	28b. Time of	28c. Injury at Work? M 1 Yes 2 No	28d. Describe how		ny)		
Divis	i di ti	Certification:	a Could not be	- At home, farm, stre (Specify)	eet, factory, office	28f. Location (Stre City or Town,	281. Location (Street and Number or Rural Route Number, City or Town, State)			
	To the Hospitel or Attentwithin 24 hours after deatl To the Funerel Director; completely filled in by the	edicai C	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of or 2 Medical Examiner: On the basis of examiner stated	camination and/or inv	occurred at the time, date and p restigation, in my opinion, death of	lace, and due to the cau occurred at the time, dat	ise(s) and manner as e and place, and due	stated. to the cause(s)		
)	To th To th	Me	29b. Signature and title of certifier MSNLST M A		29c. License number D 57531	N	Date signed (Month)	2007		
	DAI		30. Name and address of person who completed cause of deal Michiel N CG 86 CE	th (Item 23a) (Type,	Print)	Milleren	MD	o B		
	Sta Registr		31. Date filed (Month, Days Fear) 32. Begistrar's MAY 0 9 2007	Signature	Print)	,				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year Frederick Joseph Neumann 2007 /Medical May 11:10 P. 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Longview Nursing Home Manchester
If Under 1 Year | If Under 24 Hrs. | Funeral 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days XXM 2□F Director 215-14-5304 Feb. 23,1923 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r then "natural", or iteme 23a or 28e-f ehow the Medical Examiner must be notified at Director XIXYes 2 No Maryland Carroll Manchester 72 hours after death with the 10g. Citizen of What Country? United States 10e. Street and Number 10f. Zip Code 4711 Warner Drive 21102 Completed by Funeral America 12. Was Decedent Ever in U.S. Armed Forces? 120 Yes 2 No 1943— If Yes, Give Year or Dates: 1945 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: 3 ☐ Widowed 4 ☐ Divorced 1945 White 16a Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
Baltimore County
Police Officer 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10th Law Enforcement marked other other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) es 1 and 2 should be fill of Heelth and Mental H f item 27 le marked ott Be ٥ Arthur Neumann Helen Spurley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois M. Neumann (Wife) 4711 Warner Drive; Manchester, Maryland 21102 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 Iment of It May 9, 2007 1 ☐ Burial ②Comation 3 ☐ Removal from State ö 4 Donation 5 Other (Specify)
21. Signalure of Juneau Service Ligans Metro Crematory Catonsville, Maryland 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 3296 Charmil Drive; Manchester, Maryland 21102 yan1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final Physician Dement 0 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine Physician: The law requires that the death certificate be executed the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physicien by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Probably 4 Munknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed' 1 Yes 2 XNo 2 No 1 ☐ Yes After this certification funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3□ DQA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Hospital or Attending 1 (Vatural 5 Pending 1 ☐ Yes 2 ☐ No М investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide To the Hospital within 24 hours a To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M, PANSWRYA 349 POWWm 349 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 0 9 2007 Registrar

			For State	State	of Maryland		artment of H		d Menta		201	1 7	11.	000	
		4	Registrar 1. Decedent's Name (First, Middle	e Lasti		Cer	unicate of t	Jean	2 Dat	Reg.	Reg. No. 2 3. Time of			300	
	Physici	an							Mo			ear			
	/Medic		Eddie M. Nelse 4a. Facility Name (If not institution		umber)	Т	4b. City, Town, or	Location of D		May 1, 2007 4c. County of Death			2:50	PM ^M	
7	Examin	er	7601 Seans Te	. 0	umbery		4b. Oity, Town, or								
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Year	Lanhar If Under 24 I		e of Birth	Prince Georges f Birth 9. Birthplace (State or Foreign				
Ш	Director		_220-76-8645	1 ⊠ M 2□F	68	Yrs.	Months Days	Hours N	∕lin. (Mc	nth, Day, Ye 7 / 2 4 / :	Day, Year) Country)			or orgri	
	D		Usual Residence of Decedent							1/24/.	1930	TII.	nidad		
	ırylan ihow	_	10a. State 10b. County		10c. City	, Town or Lo	cation					10	d. Inside Ci		
	e Ma 3a-f s	cto	MD Prin	ce Georg	es La	nham							1 ☐ Yes	210 No	
	or 24	Director	10e. Street and Number				10f. Zip Code			10g.	Citizen of Wha	t Count	ry?		
	ath w		7601 Seans Ter				20706				United	Sta	tes		
	er de Items	Funeral	11. Marital Status	Armed F		S. 13. V	Vas Decedent of Hi f Yes, specify Cuba	ispanic Origin? in, Mexican, P	? (Specify Ye uerto Rican,	s or No- etc.)	14. Race - A Black, N				
36	s aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	ried 1 ∐ Yes If Yes, G Year or		1	∐Yes 2 /2 √No	Specify:			Specify:		_		
21215-0036	72 hours after death with the Maryland inatural", or Items 23a or 28a-f show dical Examiner must be notified at	ad k		t's Education	Dates.	16a Deced	lent's Usual Occup	ation		161	h Kind of Dusin	Bla			
Š	in 72 "na Tedic	olet	(Specify only highe	st grade completed		(Give	kind of work done o	during most of	working		b. Kind of Busin Electon		•	or	
7	iene. r thar	Completed	Elementary/Secondary (0-12)	College	(1-4or 5+)		Employe				Electon	10 1	engine	.er	
D	be filed within 72 hours after death with the Marylan ntal Hygiene. ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	Be C	17. Father's Name (First, Middle,	Last)		5011	Dimploye		Name (First,	Middle, Mai	den Surname)				
Maryland	ould be t Mental I arked or atic eve	To B	Cromwell Nels	on				Nelva	a Vern	on	•				
3	should ind Men s marke umatic	-	19a. Informant's Name/Relations	hip (Type. Print)		19b. Mailin	g Address (Street a				itv or Town. Sta	te. Zin i	Code)		
	and 2 ealth a n 27 is		Larry E. Franc	ois/Son			l Seans I					,,-	,		
Baltimore,	- 王 B 至		20a. Method of Disposition		20b. PI		of Disposition (Name of Date 20c. Location - City or T								
Ē	Pages nent of l int: If its		1 ☐ Burial		1 State		ake Crema	1	May 200		Beltsvil	le.	Marvla	and	
≣	permit. Page Department Important: If any injury or once.		21. Signature of Funeral Service		MW38.		. Name and Addres		200	/	DCTCSVII	10,	naryr		
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	100						933 Gist 2 er the mode of dyin						Approximat	e	
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Ų	海里里	ē	Sequentially list conditions, if any, leading to immediate cause. Each of the Cause (Disease or injury that initiated events	b. — Due to	(or as a consequ	ence of):						+	· · · · · ·		
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8760,	cate be executed physician and the burial-transit	dical		d											
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ROX	the death certific y the attending p ched for use as	sician/M	IF FEMALE: 23b. Was decedent pregnant		utcome pf pregnar birth 2 ☐ Fetal		Ectopic pregnancy				23d. Date of	deliver	у		
	deal le att	ici	in the past 12 months? 1 ☐ Yes 2 ☐ No		nant at time of de		Other (specify)				Month	[Day '	rear	
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Records,	law n as be 2 sh	Completed							24	a. Was an	24b. Wer	e autop	sy findings	available	
	ysiclan: The law iis certificate has bi director, page 2 sh	E								autopsy performed Yes 2	deat	h?	pletion of ca 2 □ No	ause oi	
VItal	lan: ertifica	Bec	25. Was case referred to medica					26. Place of I	-		1110	100 1		-	
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0	ng Pl		27. Manner of Death ↑ Natural 5 ☐ Pendin	28a. Date	of Injury nth, Day Year)	28b. Time of Injury	28c. Injury Work			·	injury occurred				
0	endli sath. or: A he fu	äţi	2 ☐ Accident investig	gation				∕es 2 □ No							
UIVISION	er de irecta	Certification:	3 ☐ Suicide 6 ☐ Could I 4 ☐ Homicide determ	ined 200, Plac	e of injury - At hor ding, etc. (Specify)	ne, farm, stre	et, factory, office		28f. Loc	ation (Stree or Town, S	t and Number o	r Rural	Route Num	ber,	
	ital or rs aff	Ö		1					14						
	Hosp 4 hou Tune ely fil	ca	(Check only 2 Medical	g Physician: To th Examiner: On the	e best of my know basis of examinati	vledge, death ion and/or inv	occurred at the time	e, date and pl	lace, and due	to the caus	e(s) and manne	er as sta	ited.	9)	
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral directors.	Medical	Orie)	and mai	nner stated.									7	
	No To Cor.	2	29b. Signature and title of certifie	Λ		_	29c. License			29d.	Date signed (M				
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	15		30. Name and address of person		,	, , , , ,		+ MD 04	0770						
	1		Sajeev Anand M					L MD 20	0770				<u> </u>		
	Sta Registra		31. Date filed (Month, Day, Year) MAY 0 9	2007	Registrar's Signati	La	19.3								
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			Please For State Registrar	State of		d / Depa		t of H	ealth a		ental Hyg	_	7	14984		
	Physici	an	Decedent's Name (First, Middle, La		_eroy N	Neat					2. Date of Dea Month	th ay ^{Day} 2007	Year	3. Time of Death 2:35 a. M		
	/Medic Examin		4a. Facility Name (If not institution, giv		er)		4b. City,	Town, or	Location o		mbia	4c. County		ward		
	Funeral Director		5. Social Security Number 6. S		Age (In yrs. I		If Under Months	1 Year Days	ff Under 2 Hours		B. Date of Birth lovember	9. Birthplace (State or Forei Count Oregon				
	Aaryland f ehow	ō	Usual Residence of Decedent 10a. State 10b. County	oward	10c. City	r, Town or Lo	ecation	С	olumbia	а				10d. Inside City Limits 1 ☐ Yes 2 No		
	with the face 28a-	Funeral Director	Maryland H 10e. Street and Number 5360 High Tor Hill	owaru			10f. Zip		210		1	10g. Citizen of V	What Cou	-	_	
9036	Pages 1 an ment of Heal ant: If item; ury or other	<u>주</u>	11. Marital Status 1 Never Mamied 275 Married 3 Widowed 4 Divorced	12. Was Decedor Armed Force 1 Decedor 1 Decedor 1 Pes, Give Year or Date	ONO 196		Was Deced If Yes, spec 1 ☐ Yes 2	ify Cuba	spanic Oric n, Mexican Specify:	gin? (Spec i, Puerto P	city Yes or No- lican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White				
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land 2		To Be C	17. Father's Name (First, Middle, Last Hallet	Ernest Neat					18. Mothe	r's Name		Maiden Sumam olores Vog				
			19a. Informant's Name/Relationship (Vife		5360 Hi	gh Tor		lumbia	, Maryland					
altimore,			20a. Method of Disposition 17SABurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of the Contro		ate	lace of Dispo emetery, crei Crest Law	natory or o vn Mem	orial C	Sardens	05/1	11/2007	20c. Location - Marri		own, State le, Maryland		
Balt	permit Pag Depertment Important: I eny injury o		21. Signature of Funeral Sarvice Lice	Bholit	Mois	73	3	Slack F 8871 C	Funeral Old Colu	Home, ımbia F	Pike Ellicot	t City, MD	21043			
	Pnysician /Medical Examiner		23a. Part 1. Enter the deease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):													
1760,	ite be executed iysiclan and ne buriel-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	r as a consequ					-						
P.O. Box 68	law requires thet the death certificate es been signed by the attending phys 2 should be deteched for use es the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		h 2 ∏ Feta nt at time of d	Ideath 3	Ectopic pr						te of deliventh	very Day Year		
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	gn enth	ation: To	27 Manner of Death Naturaf 5 Pending 2 Accident investigation	28a. Date of (Month)		28b. Time of finfury		Bc. Injun Worl		2		ow injury occur.				
Division	5 th 15 c	Certification:	3 Suicide 6 Could not l	289. Place 0	f Injury - At ho g, etc. <i>(Specif</i>	ome, farm, st	reet, factory	y, office		2	28f. Location (S City or Tow		per or Ru	ral Route Number,		
	To the Hospital within 24 hours of To the Funeral completely filled	edical	(Check only 2 Medical Exa	hysician: To the b miner: On the bas and manne	is of examina		vestigation	, in my o	pinion, dea		ed at the time,	date and place,	and due	to the cause(s)		
)		Σ	29b. Signature and title of certifier		mi)	1)	L. Licensi	e number	9	l	29d. Date signe	8 1	2007		
	15x1		30. Name and address of person with Children to the State of the State	no 1	of death (Ifen 1055 gistrar's Signa	uttle	Patr	Wli	y R	wy	Colu	ntia	M	21044		
Di	Sta Regist	_	****	2007	ture ,	K A	and i								_	
- 51	17 1164 1/2			•		ORIG	INAL									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** Month Vear /Medical Wanda Palmer
4a. Facility Name (If not institution, give street and number) May 45 PM 3, 4c. County of Death 4b. City, Town, or Location of Death Examiner Gilchrist Center for Hospice Care Baltimore If Under 1 Year | ITUNDE 29 Phs. Date of Birth (Month, Day, Year) ce (State or Foreign **Funeral** Days Hours Min 1 M 2 2 Director Usual Residence of Deceden 10/17/1921 MD permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐Yes 3☐No Parkville | 10f. Zip Code MD Baltimore 10e. Street and Number 10g. Citizen of What Country? 3111 Dubois Avenue
Marital Status
12. Was Decedent Ever in U.S.
Armed Forces? Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) USA 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐No Specify: þ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industr 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) restaurant waitress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Anthony Jakowski Ida _Ogarski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Palmer/Son 3111 Dubois Avenue Parkville, MD 21234

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) May 7 Beltsville, Maryland Chesapeake Crematory 2007 21. Signature of Funeral Service Licensee Cremation and Funeral Alternatives 23a. Part1. Einer the disease, or complications that caused the death. Do not enter the mode of lying, such as call lac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** mont /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and burial-trar Due to (or as a consequence of): physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) tos 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Division or Vital Records, P.O. Box 68760, To the Funeral

State

Registrar

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) 32 Registrar's Signature

30. Name and address of person who completed cause of beath (Item 23a) (Type, Print)

6 BM

701 N. Charle, St. Balts. Md

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month ARTHUR 4:45 PM MA /Medical 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BON SECOURS OSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Mountry) 6. Sex **Funeral** 1 XM 2 ☐ F Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Funeral Director 1 Yes 2 No mor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ 3 ☐ Widowed 4 ☐ Divorced Ü Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 har 19a. Informant's Name/Relationship (Type. Print) Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) atterson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 ☐Removal from State 4 Donation 5 Dother (Specify) emetery 122. Name and Address Pacility
Toseph L. Russ 21. Signature of Funeral Service License Joseph 2222 23a. Part I Enter the divease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine.

Immediate Cause (Final disease or condition resulting in death) Approximate Interval Between Onset and Death **Physician** 05 /Medical Due to (or as a consequence **Examiner** Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed in 24 hours after death Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Medical Certification: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No 1 Tyes ☑ hpatient 2 ER/Outpatient 3 DOA this Manner of Di ath Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After t 28d. Describe how injury occurred 5 ☐ Pending investigation Injury Accident ithin 24 hours after death.

the Funeral Director: A pupletely filled in by the fu 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide tifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only within 2 29b. Signature and little of certifie 29c. License number 1 mas 30. Name ar person who completed cause of death (Item 23a) (Type) h 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 2007 8:30 A Rosalie Sudano Rogers May /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore Gilchrist Center <u>Baltimore</u> If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F Director March 4, 1946 218-44-6419 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2X No Maryland Baltimore White Marsh 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r death v 21162 5611 Gunpowder Road U. S. A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or iter any injury or other traumatic event, the Medical Examines once. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Motor Coach Operator Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Victor Savalina Sophie Hoffman ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth Rogers (Husband) 5611 Gunpowder Road, White Marsh, Md. 21162 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 05/10/2007 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Homes The 9705 Belair Road, Baltimore, Maryalnd 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and sthe burial-trans Due to (or as a consequence of) Physician/Medical attending pt d for use as t IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1☐ Yes 2 No 9☐ Unknown Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of 24a Was an has autopsy death? 1 ☐ Yes 2 No 1☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence Hospital: No. 6 Other (Specify) HOSPICS 1 🗌 Yes 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

certificate be executed Box 68760, o. Division or Vital Records, P. Physician: Hospital or Attending within 24 hours after death.

To the Funeral Director; A completely filled in by the fu To the

Baltimore, Maryland 21215-0036

10

State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

BOY O 9

pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

555 N. Tassataun Blud/Balto 31. Date filed (Month, Day, Year)

		1- For State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.							14,988								
	Physici	an	Decedent's Name (First, Middle,)	Last)	Robe	180	^		2. Date of De Month		Year	3. Time of Death					
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	Funeral		, , , , ,	. Sex 7. Ag 1 ☐ M 2 1 ☐ F	e (In yrs. last birt	hday) If Und Month	ler 1 Year s Days	If Under 24 Hours A	Min. (Month, Da	y, Year)	9. Birth						
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98	72 hours after death with the Maryland natural; or Iteme 23a or 28a-f ehow dical Evand ar must be notified at	/ Fur	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 🗶☐ If Yes, Give			ecify Cuba	n, Mexican, P Specify:	uerto Rican, etc.)	Spec	lack, White,						
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Ĕ			17. Father's Name (First, Middle, La	st)					Name (First, Middle	Maiden Sum	ame)						
Ž	2 should and Ment		Oswald Harmon 19a. Informant's Name/Relationship	(Type, Print)	19b.	Mailing Addre	ss (Street a		e Rowe	ar City or Tow	m State Zir	Code)					
	Health tem 27 other tr		Paula Roberts						, Baltim								
9			20a. Method of Disposition 1 □ Burial 2 X Cremation 3	Removal from State	20b. Place of	Disposition (A	ame of		Date	20c. Location							
ţ.	permit. Pages Depertment of I Important: If it eny injury or o		4 ☐ Donation 5 ☐ Other (Spe	city)	Metro				5/9/07	Balt	imore	, Md					
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	Physician /Medical Examiner		23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused	the death. Do n	4300 ot enter the m	Waba ode of dying	Sh. Ave g, such as car	e, Balti diac or respiratory a	more, rrest,	Md 2	Approximate					
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Вох 6	leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome						23d. D	Date of delive	arv					
œ i	death certifi e attending i ed for use as	sicia	in the past 12 months? 1 ☐ Yes 2 ☑ No	1∐Live birth 4☐Pregnant at 9☐Unknown	2 ☐ Fetal death time of death	3 □Ectopic 5 □ Other (Month	Day Year					
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ds,	urres t signe Id be c	d by	Fait ii. Other significant conditions	contributing to death b	at not resulting in	the underlying	cause give	n in Part I.	1 🗆 1	/	3 ☐ Prob	ne cause of death?					
Ö	The law requires sete hes been sign page 2 should be	Completed							24a. Was	an 24b	. Were auto	psy findings available					
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	Examin	Con	4a. Facility Name (If not institution, give	street and number) LITAN HOSPITAL	4b. City, Town, or Location of Death BALTIMORE	1	c. County of Death	
	Funeral Director		5. Social Security Number 6. S 220-22-1496			8. Date of Birth (Month Day, Yea 06 30 1	9. Birthp	place (State or Foreign
	yland how		Usuaf Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo			1	10d. Inside City Limits 1 Yes 2 □ No
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5-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan Health and Mental Hygiene. Itsm 27 is marked other than "natural", or Items 23a or 28a-f show titem 27 is marked other than "natural La colified at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	1 TYes 2 NO	Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto	ecity Yes of No- Rican, etc.)	14. Race - Americ Black, White, Specify:	
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Mar	nd 2 sho alth and 27 is m		19a. Informant's Narra Relationship (19b. Maili (5ister) 1634	ng Address (Street and Number or Pu	2.11	y or Town, State, Zip	1218
Jore,	8 ° = 5		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification of the control	Removal from State	osition (Name of matory or other place)	Date 20c.	Location - City or To	own, State
Baltimore,	Parmit. Par Department		21. Signature of Funeral Service Lines		2. Nama and Address of Cicilia	gre fune	ruser	vices
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ord		eted	- congestin	le heart fait	noch -	1 ☐ Yes		bably 4 Unknown
il Rec	The law	Completed	Cardionyopath	y, diabetes me	elifus.	autopsy performed 1 ☐ Yes 2 ☑	? death?	opsy findings available ompletion of cause of
Vita	Hospitel or Attending Physicien: 14 hours after death. Funeral Director: After this centificiely filled in by the funeral director.	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Propatient 2 ER/Outpatie	Other	ith (Check only one) iome 5 - Residence	6 □Other (Spec	(fy)
n of			27. Manner of Death 1 Death 5 □ Pending	28a. Date of Injury (Month, Day Year) 28b. Time Injury		28d. Describe how in		
Division of Vital Records,		Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	00 Place of fairn. At home farm s		28f. Location (Street City or Town, St	and Number or Rur late)	ral Route Number,
		Medical C		hysician: To the best of my knowledge, dea miner: On the basis of examination and/or i and manner stated.				
	To the within 2 To the comple	Me	29b. Signature and title of certifier	NA	29c. License number		Date signed (Month,	
			30. Name and address of person who	completed cause of death (Item 23a) (Type	Res. 00	0 0	>/ O T/ C	シ '
	7		NABIL ZE	FINEH, 5601 L	CH RAVEN (Slud. BA	LTIMORE	MD, 21239
48	St Regist	ate rar	31. Date filed (Month, Day, Year) MAY 0 9 20	2. Registrar's Signature	well .			

State of Maryland / Department of Health and Mental Hygiene,

14990 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** Donna Rudie 2007 9:00 AM /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Keswick Home Baltomore 5. Social Security Number 7. Age (In yrs. lest birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 02/23/1929 6. Sex Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1□M 21F 166-20-3846 Director PA Usual Residence of Decedent death with the Marylend 10a. Stete 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23s or 28s-f show other treumstic event, the Medical Examiner must be notified at 10d. Inside City Limits MD Director Baltimore 1 ☐ Yes 2 ☑ No Towson 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 200 Towson Town Ct. 21204 USA Funerai 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. pernit. Peges 1 end 2 should be filed within 72 hours efter of Department of Health and Mental Hygiene. Important: If item 27 ia marked other than "natural", or item any injury or other traumatic event, the Medical Examina. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: altimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White 2 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Public Education Elementary/Secondary (0-12) College (1-4or 5+) Teacher 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harry Mutchler Bertha Collins r 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sheldon Rudie/Husband 200 Towson Town Ct. Towson, MD 21204 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Mav B 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crematory Inc. 2007 Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, Maryland 21286-M01443 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician /Medical Immediate Cause (Final disease or condition resulting in death) Recurrent preumoura

Due to (or as a consequence of): Examiner Years. Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours either death.

To the Funeral Director: Atten this certificate has been signed by the attending physician and compilely filled in by the funerel director, page 2 should be detached for use as the burial-transit physiclan and s the bunal-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Lest Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Cerebranascular disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ Be Completed 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 1 ☐ Yes 2 19 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2⊡ No Medical Certification: To 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Yeer) > 7 babelle Mas gre gre or 9 013657 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) MARGARER, 700 W. 40th STREET, BALTITIRE, O IS BELLE 31. Dete filed (Month, Day, Year) 32. gistrer's Signature State Breve H. Garle Registrar

07-03266	
Kenton Rusch	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No Registrar Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Time of Death Month Day April 29, 2007 **Medical Examiner** Kenton James Rusch 1250 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital **Baltimore City** 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In vrs. last birthday) **Funeral** oreign MN Months Davs · Hours 03-09-1933 Director 476-28-1009 74 1 X M 2 F Usual Residence of Decedent any 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore MD , or items 23a or 28a-f show 1 X Yes 2 No the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3939 Roland Ave #302 21214 USA hours after death with Funeral 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian, Black If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. 1 Never Married Yes 4 X Divorced Yes 2 X No specify: White Widowed If Yes, Give Year Specify: more, MD 21215-0036

Pages I and 2 should be filed within 72 hours after near of Health and Mental Hygene.
ant. If item 27 is marked other than "natural", ro other traumatic event, the Medical Examiner. <u>ج</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Unknown Painter Painting 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) William Rusch Ellen Miller Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kris Rusch/daughter 1835 Madison Ave Baltimore, MD 21217 Baltimore, N permit Pages I and Department of Healt 20c. Location - City or Town, State 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery. Date Burial 2 X Cremation 3 Removal from State crematory or other place) Chesapeake Crematory 5/7/07 Beltsville, MD ant: Donation 5 Other Specify or 22. Name and Address of Facility CAFA 21 Signature of Funeral Service Licenses 8717 Green Pastures Dr Towson MD 21286 Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line Between Onset and /Medical Death Atherosclerotic cardiovascular disease Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Examiner Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. and Physician/Medical X UNPENDED signed by the attending physician be detached for use as the burial -#23a,27,perMEg867, 5/10/07 TT Division of Vital Records, P.O. Box 68760, IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Yea Fetal death past 12 months' Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 V Unknown Completed After this certificate has been funeral director, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 1 🗸 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other4 Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 1 Yes No 28a. Date of Injury (Month, Day,Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural Yes 2 No Director: d in by the ! Pending 2 Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) determined (Specify) To the Funeral 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) O.C.M.E. April 30, 2007 oked 30. Name and address of person who complete cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Theodore M. King, Jr., MD. 31. Date filed (Month, Day, Year) 32. Rastrar's Signature State

DHMH 17 Rev 1/2001 **OCME 2006**

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Amend #29c,30, per DVR, G867, 5/9/07 Ertificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year Month **Physician** 2001 1810 Ri11 mai Marv Ε. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Easfon 1 Year | If Under 24 Hrs. Talbo memorcas Hospita If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 21 F Months Days Hours Min. Director 213-18-3917 1921 Maryland Mar Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County or 28a-f show other traumatic event, the M-di-al Examiner must be notified at 1 ☐ Yes 21 No Director MD Talbot Easton 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 28466 Waterview Drive 21601 "natural", or items 23a U.S.A. by Funeral Pages 1 and 2 should be filed within 72 hours after death a nent of Health and Mental Hygiene. nt: If item 27 is marked other than "natural", or items 23. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 █XNo Maryland 21215-0036 Specify Specify: 3 ☑ Widowed 4 ☐ Divorced White Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Housewife Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ျှ Jacob Fulton Roop Sallie Leight 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dale Rauch Daughter 28466 Waterview Drive Easton, MD 21601 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any Injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Emory Chapel Cem. 5/10/07 Upperco, MD permit. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 11824 Reisterstown Road 510 ELINE FUNERAL HOME Reisterstown, MD 21136 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician year /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ROSS The law requires that the death certificate be executed and Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) the 9 Unknown s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 1 Tyes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performe has page 2 2 No this certificate 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 1 □ Yes Medical Certification: To 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D46020 516107 SOM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Syed I. Ali, MD Memorial Hospital @ Faston Easton, MD 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Vear CATHERINE LESLIE REARDON 2007 6:30 A. /Medical MAY 6, 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FOREST HEALTH & REHAB CENTER FOREST HILL HARFORD If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 □ M 2 🔀 F **Director** 080-16-4156 84 Jul. 24, 1922 New York Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at Director 1 ☐ Yes 2X No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 204 Briarcliff Lane USA Funeral 21014 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ XNo Specify. þ 3X Widowed 4 ☐ Divorced Specify: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Hame permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any finity or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lester Stamwood Colie Katherine P. Ernst 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 204 Briarcliff Lane, Bel Air, Maryland 21014

f Disposition (Name of Date 20c. Location - City or Town, State Maureen Susan Guidi/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Calverton National Ce 5-10-07 Calverton, New York 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
McComas Funeral Home, P.A. Kussell Sly 50 W. Broadway, Bel Air, Maryland 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a constituence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and burial-trar Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>≨</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performe 2 No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 2 ER/Outpatient 3 DOA Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury investigation 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

Registrar DHMH 17 Rev 1/2001

State

(Check only one)

DAVID DUNN

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MAY 0 9 2007

3altimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

and manner stated

615 W. MACPHAIL ROAD

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D32255

BEL AIR, MD.

21014

29d. Date signed (Month, Day, Year)

7

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year Wolfgang 1625 M **Physician** 05 06 07 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Cita Baldinere HOS PITEL Sinai If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08/07/1930 6. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 X M 2 □ F Months Days Hours ĞERMANY 212-30-4151 76 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or items 23a or 28a-f shovedical Examiner myst be notified at 1 X Yes 2 No Director N/A MD BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number **USA** 21215 3501 TANEY ROAD Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married WHITE 1 ☐ Yes 2 No Maryland 21215-0036 Specify. ģ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) CPA ACCOUNTING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ROTENBERG ROSA POLLACK SAMUEL ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3501 TANEY ROAD, BALTIMORE, RENA ROTENBERG / WIFE MD 21215 Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition CHEVRA AHAVAS "CHESED INC. 1 Burial 2 Cremation 3 Removal from State 05/07/2007 RANDALLSTOWN, MD 5 Other (Specify) 4 Denation 21. Signature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Intracere **Physician** /Medical Due to (or as a consequence of): Examiner Myocardial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Atrial arythmia The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 TUnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 3 Probably 4 Unknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of MSY 24a. Was an autopsy performed Yes 2 mellitus Dialetes 2 🗆 No 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760, within 24

witgarg

State

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Khurchen

Medical

tishel

29c. License number D 28855

Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 050607

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rhanda Fighe (MD Sirvin HOSP Hall of, Ballimore 2401 WBelvedere.

31. Date filed (Month, Day, Year) 2007 MAY 0 9

32. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician May 04 2007 6PM ROSKELLY MARGARET Μ. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Marley Neck4b. City, Town, or Location of Death **Examiner** Millennium Heath & Rehab. Center at Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 24,1915 6. Sex 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Maryland Months Min. Days Hours 1 M 2 W F 220-20-6147 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event. The Mention 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 No Director Maryland Anne Arundel Pasadena 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8395 Forest Drive 21122 U.S.A. Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 1 No White Saltimore, Maryland 21215-0036 Specify: ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Emrich Mary Nichol Philip ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8395 Forest Drive, Pasadena, Maryland 21122 Μ. Bea11 (daughter) 20c, Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 Removal from State 05-08-07 Loudon Park Cem. Baltimore, Maryland 4 Donation 5 Dother (Specify) ^{22. Name and Address of Facility.} McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be execute burlal-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy ģ in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4□Pregnant at time of death 9 ☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death ģ 4 Unknown 2 □ No 3 ☐ Probably 1 ☐ Yes page 2 should Be Completed Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2/10 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 1 ☐ Yes 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier within 24 hor To the Fune completely fi Medica (Check only one) and manner stated 29d. Date signed (Month, Day, Year)

State Registrar 29b. Signature and tifle of

31. Date filed (Month, Day, Year)

5410-A Ritchie Highway, Baltimore, Maryland

Mi

2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Harjit Singh,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month MAY **Physician** ROUX 2007 05:40FM TERRI /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner Center Towson Baltimore 8. Date of Birth (Month, Day, Year) 12-11-1957 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Days Hours Months Director 216-78-1971 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show Examiner must be notified at Baltimore 1√2Yes 2□No NA Director Md. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with ō 21234 USA 62 Solar Circle Items 23a Funeral Pages 1 and 2 should be filed within 72 hours after death 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 'natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Various Nuring Assistant 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cumming Rooks Mary Charles ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, permit. Pages 1 and 2 s
Department of Health ar
Important; if Item 27 Is
any Injury or other trau 21202 62 Solar Circle, Baltimore, Md. Husband Charles H. Roux 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Md. 5-9-07 Garden of Faith 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility F.H East March 21202 Md. 1101 E. North Ave., Baltimore, an 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final YEARS METASTATIC BREAST CARCINOMA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed after death. attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy signed by the atter Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ģ page 2 should

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funeral director,

After this

neral Director; /

Certification: To

1 □ Yes 2 □ No 9 □ Unknown	9□Unknown						
Part II. Other significant conditions of	ontributing to death but not res	ulting in the underlying	cause given in Part I.		se contribute to the cause of death? PNo 3 □ Probably 4 □ Unknow		
				24a. Was an autopsy performed? 1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No		
25. Was case referred to medical examiner? 1 ☐ Yes 2/12 No	26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)						
27. Mann of Death 1 DNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	y occurred		
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At h building, etc. (Special	ome, farm, street, factory)	28f. Location (Street and City or Town, State)	 Location (Street and Number or Rural Route Number, City or Town, State) 			
	ysician: To the best of my kno niner: On the basis of examina				and manner as stated. place, and due to the cause(s)		

To the Hospital of within 24 hours af To the Funeral D

Registrar

Medical

29b. Signature and title

29c. License number

29d. Date signed (Month, Day, Year)

D25886 30. Name and address of person who completed cause of de h (Item 23a) (Type, Print)

and manner stated

7601 M. D. OSLER DRIVE TOWSON. MARYLAND CEBALLOS. _IA

31. Date filed (Month, Day, Year) MAY 0 9 2007

(Check only one)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Johns Hopkins Bayview Med. Center Baltimore 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 □ M 2 🗷 F 220-26-3156 86 Jan. 18,1921 Pennsylvania Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, th∗ Medic⊸l Examiner must be notified at 1 Yes 2 No Director Delaware Sussex Seaford 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 111 S. Tull Drive 19973 U.S.A. Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify Completed by 3 Widowed 4 □ Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Apartment Manager Personnel 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Arthur Hughey Louise Eddy ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh
Department of Health and
Important: If item 27 is n
any Injury or other traun
once. Carroll J. Robinson Jr. (Son) 38034 Mockingbird Lane Unit 7, Selbyville, Delaware 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State Cedar Hill Cemetery 05-07-07 Brooklyn Park, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122 21. Signature of Funeral Service License Kink xinl rt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (F as a consequence of): week **Physician** /Medical Examiner Stric cance Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) detached the 9 I Inknown 9 Unknown wate nas been signed by the page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 | Yes 2 | No 3 | Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an has ! autonsy performed? Yes 22 No certificate Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 21 No 1 ☐ Yes 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 MInpatient After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident hours after death uneral Director: the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier JOS IN

Registrar

DHMH 17 Rev 1/2001

State

MM

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signat

Rosentha

Year)

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend #7,8,15,17,20a-b, perFH, g867, 504 Whotate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death Day Year 11:32 AM **Physician** May Kobinson 200 nera Z /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Bale W If Under 1 Year Months Days Boltimore timore ed | If Under 24 Hrs. | 8. Date of Birth | Hours | Min. | Min. | Mar. 4, 1959 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral 216-76-5863 Usual Residence of Decedent 1**∑**M 2□F 48 Director with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Ex milier must be notified at 1 Yes 2 No **Funeral Director** timore APT. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number d 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race -American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 1 No Specify. Maryland 21215-0036 à 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 11 er 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Important: If item 27 is marker any Injury or other traumatic eonce. Johnnie Robinson Pages 1 and 2 should ೭ oinson binson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (wife) 212/5 HUR Mrs. Veneita Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition of 1 X Burial 2 ☐ Cremation 3 ☐Removal from State Mt. Cannel 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
Joseph L. Russ
2222 W. North 21. Signature of Funeral Service Licensee Home, P.A. Joseph 2222 neral 23a. Part Enter the difease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sepsis **Physician** Month disease or condition resulting in death) /Medical Due to (or as a consequence of) mmunodeficiency Syndrome Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Be Completed by Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) director, page 2 should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No this certificate 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To funeral (28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 □ Yes 2∏No within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide t 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 Sinai MOYE 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar MAY 08 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** EDITH E. SANTANA MAY 07 2007 7:30A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner BALTIMORE CITY 4815 PLEASANT VIEW AVENUE (In yrs. last birthday) 97 Yrs If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01/02/1910 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Days 1 ☐ M 2X F MARYLAND 219-01-7664 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits me 23a or 28a-f ehov BALTIMORE CITY N/A 1 ☑ Yes 2 ☐ No MD Director 10f. Zip Code 21206 10g. Citizen of What Country? 10e. Street and Number USA 4815 PLEASANT VIEW AVENUE Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? or iteme 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. In 27 le marked other then "natural", or Itel 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: BLACK à XXWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) CATERING FOOD SERVICE 8TH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be BERTHA FAIDLEY COLONEL FLICKS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Peges 1 and 2
Department of Health an Importent: if item 27 le n. eny injury or other 100cg. 4815 PLEASANT VIEW AVE, BALTIMORE, MD 21206 DOLORES GREEN / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place)
MD VETERANS CEM.
CROWNSVILLE 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 5/10/07 CROWNSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD to Drifter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death END Step diate Cause (Final 3 months **Physician** disease of condition resulting in death) /Medical Examiner Bilian if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physicien and for use as the burial-transit certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Š HIV 2004 1 Yes 2 No 3 Probably 4 Onknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 1□ Yes 2 No Division of Vital or Attending Physician: 26. Place of Death | Check only one 25. Was case referred to medical examiner? Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Yes 2 No 7 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28 Describe how injury occurred 27 Manner of Death 28b Time of 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation Accident within 24 hours after death To the Funerel Director: / completely filled in by the f 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge death occurred at the time, date and place, and due to the cauce(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Cartifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D24321 Konto 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BACTIMORE BLUD. PHILLIP KONITZ, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Georgina Mildred Srb 2, 2007 May 12:45 P M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4c. County of Death 4b. City. Town, or Location of Death Riverview Care Center Baltimore Essex 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 ☐ M 2 🛱 F Months Days Hours Director 213-58-1072 89 March 26,1918 Maryland Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location irel", or frems 23a or 28e-f show 10d. Inside City Limits Director 1 ☐ Yes 2 📉 No Maryland Baltimore Nottingham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17 Farwell Ct. 21236 Funerai U. S. A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hyglene. Importent: if item 27 is marked other then "neturel", or Item any injury or other treumatic event, the Modical East in expone. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ρ 3 Nidowed 4 Divorced Specify. White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Karel Cepl 2 Barbara Vanura 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Georgina L. LaCombe (Dghtr) 17 Farewell Ct., Nottingham, Maryland 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Bohemian National Cem. 05/07/2007 Baltimore, Maryland 21. Signature of Fone al Service Leaning 22. Name and Address of Facility Schimunek Funeral Homes 9705 Belair Road, Baltimore, Maryalnd 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ATHEROSCLE ROTIC CARDIOVASCULAR

Due to (or as a consequence of):

DISEASE Physician disease or condition resulting in death) /Medical Examiner HYPERTENSION if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner HYPOTHYROIDISM and I-transit certificate be executed that initiated events resulting in death) Last as the burial-Box 68760, the attending physician ANEMIA Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Year 4 Pregnant at time of death 5 Other (specify) Day signed by the a d be detached for P.O. 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ bnknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 280 No 1 Yes 2 DNO 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 41 Jursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ Yo 2 28a. Date of Injury (Month, Day Year) 27. Manney Death 28b. Time of Injury Certification: 28c. Injury at Work? 28d. Describe how injury occurred To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After 1 Latural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

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who completed cause of death (Item 23a) (Type, Print)

3. Registrar's Signature

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